EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA
CIVIL ACTION FILE NO. 1:23-CV-480

PLANNED PARENTHOOD SOUTH ATLANTIC, et al.,

Plaintiffs,

vs.

JOSHUA STEIN, et al.,

Defendants

and

PHILIP E. BERGER and TIMOTHY K. MOORE,

Intervenor-Defendants

VIDEO CONFERENCE DEPOSITION
OF
CHRISTY MARIE BORAAS ALSLEBEN, MD

TAKEN VIA VIDEO CONFERENCE AT THE OFFICES OF:
CHAPLIN AND ASSOCIATES, INC.
NETWORKING WITH:
CAPE FEAR COURT REPORTING, INC.

08-29-2023
10:06 O'CLOCK A.M.

Gretchen Wells
Court Reporter

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I N D E X

E X H I B I T S

Name	Offered By	Identified
Exhibit A (Declaration of Deponent)	All parties	7

NOTE: Quoted material has been reproduced as read or quoted by the speaker.

STIPULATIONS

Pursuant to Notice and/or consent of the parties, the deposition hereon captioned was conducted at the time and location indicated and was conducted before Gretchen Wells, Notary Public in and for the County of Iredell, State of North Carolina at Large.

Notice and/or defect in Notice of time, place, purpose and method of taking the deposition was waived. Formalities with regard to sealing and filing the deposition were waived, and it is stipulated that the original transcript, upon being certified by the undersigned court reporter, shall be made available for use in accordance with the applicable rules as amended.

It is stipulated that objections to questions and motions to strike answers are reserved until the testimony, or any part thereof, is offered for evidence, except that objection to the form of any question shall be noted herein at the time of the taking of the testimony.

Reading and signing of the testimony was requested prior to the filing of same for use as permitted by applicable rule(s).

PROCEEDINGS

(10:06 o'clock a.m.)

THE COURT REPORTER: We are now on the record. Today's date is Tuesday, August 29th, 2023, and the time is 10:06 a.m. This is the deposition of Dr. Boraas taken in the matter of Planned Parenthood South Atlantic, et al., versus Joshua Stein, et al., Defendants, and Philip E. Berger and Timothy K. Moore in the United States Court for the Middle District of North Carolina, Civil Action File Number 1:23-CV-480.

The witness has signed a Declaration of Deponent which will be attached to the transcript as Exhibit A.

(DEPOSITION EXHIBIT
LETTER A WAS MARKED
FOR IDENTIFICATION)

THE COURT REPORTER: I'll ask the attorneys to please introduce yourselves and who you represent, and indicate for the record whether anyone else is present in the room with you.

MR. BOYLE: Good morning. My name is Ellis Boyle. I represent the Legislative Leader Defendants, Senator Berger and Speaker Moore. No one else is in the room with me. And I am joined by my co-counsel, Julia Payne and Denise Harle. I'll let

them say whether anyone is in the room with them. And my clients' lawyer, Joshua Yost, is also joining us.

MS. PAYNE: This is Julia Payne with the Alliance Defending Freedom. No one is here with me. I'm in my office by myself.

MS. HARLE: Denise Harle here. No one is joining me.

MR. YOST: Joshua Yost, general counsel for Senator Berger, and no one else is in the room with me.

MS. GRANDIN: Good morning everyone. My name is Kara Grandin, counsel for Planned Parenthood South Atlantic. No one else is in the room with me. I am joined by co-counsel from Planned Parenthood Federation of America and the ACLU. I'll let them introduce themselves as well.

MS. SALVADOR: Hi. Anjali Salvador, also co-counsel for Planned Parenthood South Atlantic. No one is in the room for -- with me.

MR. BOYLE: You're on mute.

MS. SWANSON: Thanks. This is Hannah Swanson, also for Planned Parenthood South Atlantic, and no one is in the room with me.

MS. AMIRI: And this is Brigitte Amiri from the ACLU, representing Dr. Gray, and no one else

is in the room with me.

MR. MENDIAS: This is Ryan Mendias, also for Dr. Gray, also with the ACLU, and no one is in the room with me.

MR. MOORE: Hi. My name is South Moore. I'm at the North Carolina Department of Justice, and I'm representing Attorney General Josh Stein. No one else is in the room with me.

MS. MAFFETORE: Apologies, one more for Plaintiffs.

MR. MOORE: I'm sorry.

MS. MAFFETORE: My name is Jaclyn Maffetore. I'm with the ACLU of North Carolina. I represent all Plaintiffs in this matter, and nobody's in the room with me.

MR. BULLERI: I'm Michael Bulleri. I represent the North Carolina Medical Board, North Carolina Board of Nursing, and no one is in the room with me.

MR. WILLIAMS: Good morning everyone. My name is Kevin Williams, and I represent District Attorney Jim O'Neill, and no one is in the room with me.

MS. CROWLEY: Colleen Crowley, with the North Carolina Department of Justice, and I represent

DHHS, and no one is in the room with me.

MS. O'BRIEN: Good morning. I'm Elizabeth Curren O'Brien. I -- with North Carolina Department of Justice, and I represent the DA Defendants except for District Attorney O'Neill, who Kevin Williams represents.

THE COURT REPORTER: Okay. I believe that is everyone on my list. And since she has signed a Declaration of Deponent, we can begin.

MR. BOYLE: Very good.

THE WITNESS: I'm in the room by myself too. Just didn't want to get left out.

The witness, CHRISTY MARIE BORAAS ALSLEBEN, MD, under the penalty of perjury, testifies as follows:

EXAMINATION

BY MR. BOYLE:

Q. Very good. Good morning, Doctor. Have you ever been deposed before or given testimony under oath?

A. I have not.

Q. Okay. So obviously, we're doing this by Zoom so we're not sitting in a room. It's more formal than a normal conversation would be. There's a few ground rules I just want to run over with you.

A. Sure.

Q. You may have already heard this. If you have, I apologize for repeating it. First, the court reporter is going to be typing up and transcribing everything that we say. So it's important to make her job easier, two things.

One, that we try not to talk over each other. That can be a little tricky when you're in the Zoom context because there could be a delay. I think hopefully we'll get our sea legs as we go along and we'll try and see when one person's talking until they finish. And you're doing a great job so far.

And I may be guilty of this as well. So I apologize if we start stepping over each other with talking, I may politely try and redirect us. If I do that, please don't be offended. It's not meant to be offensive. Just trying to keep my court reporter happy. I always find that's a good thing.

A. Sure.

Q. Good. And then the second thing is nods and saying "uh-huh," those are perfectly normal in a normal conversation. Like I said, this is more formal. With transcriptions, if you nod your head up and down and you mean yes, that doesn't really translate well to the written transcript.

So as we go along, if I ask a question and I can tell what your answer is but you haven't said it out loud, I may prompt you. Again, if I do that, it's not intended to be rude at all. It's more for the formality and the court reporter. Is that okay?

A. That sounds great.

Q. Good. Doing a good job so far. Finally, there is an expectation that you will answer the questions asked even if there is an objection, absent some type of instruction from your lawyer, the lawyer representing you, to the contrary, okay?

A. Yes.

Q. Very good. Your medical specialty is in obstetrics -- I always say that wrong, obstetrics and gynecology. Is that correct?

A. Yes. I completed an obstetrics and gynecology residency.

Q. And the obstetrics part of the OB/GYN deals with pregnancy. Is that right?

A. Yes.

Q. Sometimes, you provide treatment and care to a pregnant woman as an obstetrician that leads to the birth of the pregnant woman's child. Is that right?

A. Absolutely.

Q. In that case, you would have provided

obstetrics care to the mother and child through the birth of the child. Is that right?

A. We see -- yeah. I see pregnant people in clinic all the time and provide antenatal care up until the point of birth, yes.

Q. And just -- I think I understood that, but just -- I'm a simple man. That means for the mother and the child up until the point of birth, right?

A. For the mother and the fetus, yes.

Q. And I -- I understand our terms may be a little bit different but ---

A. Uh-huh (yes).

Q. --- can we agree that, within reason, if we use a little bit different terms but we understand what each other's saying, we can just keep the conversation going with our own particular terms? Is that fair?

A. Sounds fine to me.

Q. Yeah. And I'm not asking you to adopt my terminology, and I think it's fine if you don't adopt mine. I think, typically, unborn child and fetus, I think we might be able to use interchangeably, understanding you may say fetus when I say unborn child. Is that fair?

MS. GRANDIN: Objection to form.

MR. BOYLE: This is one of those ---

THE WITNESS: So I'm going to -- you know, as a medical expert in -- for this deposition, I'm going to stick to the medical terminology that's used in science. So I'm going to stick to that for my answers.

Q. (Mr. Boyle) Yes, and I'm not suggesting you shouldn't. I'm just saying, so we keep the flow, you understand what I'm saying and I understand what you're saying. Unless there's a question, in which case please stop me and ask me to clarify, okay?

A. Yeah. Certainly, if there's -- you know, if there's certain terminology that you're using that it's -- that is not clear to me, I'll be sure to ask. Thank you.

Q. Very good. After the child is born, typically the child's care shifts over to the pediatrician, and you stop seeing the child as your patient as an obstetrician. Is that fair?

A. That is, yeah, a good characteristic of my practice. We don't -- I don't see any newborns as a patient.

Q. Okay. An induced abortion involves some mechanism to terminate a pregnancy before the birth of what would otherwise appear to be a viable pregnancy

that would lead to the birth of a baby in the absence of the induced abortion. Is that correct?

A. So induced abortion is the procedure -- using procedure or medicines to end the pregnancy without the intention of continuing the pregnancy and having -- and giving birth.

Q. And in the absence of an induced abortion, the expectation would be that it would be a viable pregnancy and eventually a child would be born?

A. Well, I mean, that's a lot of what, you know, patients and the lay public think, right? But there -- miscarriage happens in one-fifth of pregnancies, so I don't know that that's a completely accurate statement.

Q. Right. Miscarriage being an unplanned termination of the pregnancy. But absent a miscarriage, an induced abortion is meant to terminate a pregnancy that hasn't yet miscarried and, presumably, if it doesn't miscarry, would proceed all the way to the birth of the child?

A. I would say, you know, generally, that's true. However, there are certainly problems and chromosomal abnormalities. There are certainly pregnancies that continue and, for reasons that sometimes we know and sometimes we don't, you know,

end in a intrauterine fetal demise before birth.

Q. Fair enough. But not one that is intentionally induced by an abortion?

A. Not in that particular case, no.

Q. You perform surgical abortion for some pregnant women who are your patients, don't you?

A. Yes. I see pregnant people for procedural abortion.

Q. You perform chemical abortion for some pregnant women who are your patients, don't you?

THE WITNESS: I'm not sure what you ---

MS. GRANDIN: Objection to form. Go ahead. You can answer.

THE WITNESS: Sorry, Zoom. I'm not entirely sure what you mean by "chemical."

Q. (Mr. Boyle) Well, using chemicals or drugs to induce an abortion like -- well, I'm going to butcher these words, misoprotrol (sic) and Mifeprex, right?

A. So if you're -- you -- I think what you're talking about is using medicines, approved by the FDA for use in our country, to end a pregnancy in the first trimester, which would -- or second, depending on what the patient needs, to induce a -- for the mifepristone to block progesterone and the misoprostol

to cause cramping and bleeding so that the pregnancy will pass.

Q. Okay. And so I may refer to that as chemical abortion, but you may refer to it as medicine abortion. Is that sort of talking about the same thing, using those two drugs to induce an abortion?\

A. So the ---

MS. GRANDIN: Objection to form.

THE WITNESS: The medical term for that is medication abortion.

Q. (Mr. Boyle) Okay. And each of the women that you performed an induced abortion on was pregnant. Is that right?

A. For pregnant people that come to us, they've had confirmation of the pregnancy and then are requesting to end the pregnancy. And then we discuss options about how to do that.

Q. And I'm sorry, so is the answer yes, the people you performed an induced abortion on were pregnant when you did that procedure?

A. People who come requesting abortion have had confirmation of their pregnancy, yes, so they are pregnant.

Q. So every time that you performed an induced

abortion on a woman who was your pregnant -- I'm sorry, who -- a pregnant woman who was your patient, what was supposed to happen to the unborn child?

A. For people who make an appointment to discuss abortion care and then have counseling and go through informed consent and decide to proceed with either medication or procedural abortion, those people then have procedural termination of their pregnancy or termination of the pregnancy with medicines.

Q. And as an obstetrician, when you perform those induced abortions, do you consider the unborn child or the fetus to be your patient at that point?

A. I don't.

Q. How many induced abortions have you performed in your career?

A. I don't have an exact number to relay to the assembled audience here today. Many.

Q. Many like a hundred or many like a hundred thousand? Somewhere in between?

A. Somewhere between those two numbers, yes.

Q. Okay. Do you have an average per year that you -- of induced abortions that you perform?

A. I don't have an average per year, but maybe a week. I could provide probably numbers for weekly. An average week would be somewhere between five and

15. Sometimes, up to 20.

Q. Okay. So would you say an average week is ten to 12?

A. Sure.

Q. And is that 50 weeks a year?

A. I do take vacation occasionally, so yeah.

Q. So -- yeah, I mean ---

A. Forty -- 48 weeks a year.

Q. Forty. Okay, 40 weeks a year. Fair enough. Yeah.

A. Yeah.

Q. I wasn't trying to make you work all the time.

A. Yeah. Okay. Thanks.

Q. So you're talking somewhere like 400 to 450 a year would be a fair estimate?

MS. GRANDIN: Objection to form. You can answer.

THE WITNESS: Again, it's hard to give me -- give an exact number, but that's probably our best guess for today.

Q. (Mr. Boyle) And how many years have you been in this practice that that would be your typical practice?

A. I have been an attending physician since

2014.

Q. So nine, coming on ten years. Is that right?

A. Yes. But please don't age me so fast.

Q. You're far younger than me, so hopefully you won't catch up. The -- that sounded like -- that came out wrong. I apologize. You're going to get older. It's too bad.

The -- and in residency, were you doing the same rough numbers of induced abortions per year?

A. No.

Q. Would you have been doing more or less during residency?

A. Less during residency because I was learning, you know, many other aspects of obstetrics and gynecology at that time as well.

Q. How about during your two-year fellowship for advanced family planning?

A. Yeah. So my fellowship, which you are entirely correct was two years, was focused on contraception for complex -- people with complex medical conditions and clinical research, and also focused care for induced abortion and abnormal pregnancy as well as pregnancy of unknown location.

Q. Have you ever performed a chemical or

medicine abortion on a patient who was pregnant with twins?

A. Yes. Yeah, I have seen a pregnant person that requested a medication abortion in the first trimester.

Q. And they were pregnant with twins?

A. Correct.

Q. Does that change the mechanism or the process that you go through when you're performing a chemical or medicine abortion with a patient who is pregnant with twins?

A. Our process for when a patient makes an appointment with us to consider medication abortion is pretty similar regardless of the characteristics of the pregnancy.

So our process is to, you know, provide thorough informed consent, to use our extensive protocols about coercion and to ensure that people are making their best decisions for themselves, and then describe in detail expectations about what to expect with medication abortion and what signs and symptoms might prompt further follow-up.

Q. Does the fact that a patient is pregnant with twins change the actual amounts of medication or chemicals given to induce the abortion for that

patient?

A. No. The medicines are the same.

Q. Would that be true of a patient with triplets or quadruplets or more also?

MS. GRANDIN: Objection to form.

THE WITNESS: I have never provided a medication abortion for a patient that had triplets or a higher-order multiple gestation.

Q. (Mr. Boyle) How do you know that?

MS. GRANDIN: Objection to form.

THE WITNESS: I have never done that to the -- to my knowledge.

Q. (Mr. Boyle) How would you know if a pregnant patient of yours is pregnant with twins or triplets or quadruplets?

A. Typically, we would know that from ultrasound.

Q. Are there any greater risks involved with a patient who is pregnant with twins or triplets or quadruplets getting a chemical or medical abortion?

MS. GRANDIN: Objection to form.

THE WITNESS: I can really only speak to patients that I've seen that have had a twin gestation. And the answer to that part of the question is no.

Q. (Mr. Boyle) Have you seen any studies that describe that or talk about that?

A. I don't recall seeing any studies specifically discussing higher-order multiples and medication abortion.

Q. So you have your experience but you don't have any additional scientific literature or studies to support the question of whether there is a higher risk for a pregnant patient who has twins or triplets receiving a medical -- I'm sorry, medicine or chemical abortion. Is that correct?

MS. GRANDIN: Objection to form.

THE WITNESS: The risk for a person with a singleton gestation would be the -- similar to the risks of a person that has a twin gestation.

Q. (Mr. Boyle) But you don't have any studies to support that conclusion, do you?

A. At the ready, no. But I certainly could do an extensive literature search about that and get back to you about that.

Q. Is there any way to tell if a patient is pregnant with twins or triplets or quadruplets other than by taking a transvaginal ultrasound of that patient?

A. Transvaginal ultrasonography is not required

for diagnosing a multiple gestation.

Q. You can do it without an ultrasound?

A. You don't need a transvaginal one.

Q. Okay. You can -- oh, that's fair. Ultrasound is the way that you tell if your pregnant patient has twins or triplets or quadruplets, right?

A. That would be -- that would be -- yes, that -- it would be -- ultrasound is the typical way we diagnose a multiple gestation, yes.

Q. Do you think it's important to know if a pregnant patient that you're providing an induced abortion to has twins or triplets or quadruplets before you provide that induced abortion?

A. I think, given the rarity of spontaneous triplets and certainly higher-order multiple gestations for pregnant people in our country, that that would be an irrational thing to require for each person coming to access medication abortion.

Q. I'm sorry, you said "an irrational thing." What thing are you talking about?

A. Like, an irrational thing to require an ultrasound to ensure that you know whether or not a person has a singleton gestation, which is the vast majority of pregnant people, or a twin gestation, which is a very low amount of people, versus a

higher-order multiple gestation like triplets or quadruplets or quints or something crazy, which is even -- which is just even more rare. It's irrational to require transvaginal ultrasonography when safety isn't known to be improved for that.

Q. Well, you said safety isn't known to be improved but you also, I believe, said that you're not aware of any studies of the risks in -- associated with induced abortions for twins or triplets or quadruplets. Did I misstate that?

MS. GRANDIN: Objection to form.

THE WITNESS: What I -- what I want to communicate to this group is that the risks of medication abortion for somebody with a singleton gestation or a twin gestation are the same.

I don't know of any other studies for -- again, at the top of my head, because -- because the incidence of triplets, quadruplets, quints is so exceedingly rare that there wouldn't -- I would not be surprised if there aren't studies about that because it is so rare.

Q. (Mr. Boyle) Is there any increased risk for performing a surgical abortion on a patient who is pregnant with twins or triplets or quadruplets?

MS. GRANDIN: Objection to form.

THE WITNESS: In the first trimester, no.

Q. (Mr. Boyle) Have you seen any studies that support your opinion on that?

A. Not that I recall at this moment.

Q. So you're unaware of any independent corroborating scientific literature to support that opinion, but that's your opinion. Is that what you're saying?

A. Again, it's really hard -- with the vast amount of literature on this topic, it's really hard to keep all of that in my brain at one time. But I certainly am well versed at extensive literature searches and could produce that if you -- if need be.

Q. Well ---

A. If it exists.

Q. Sorry.

A. Sorry.

Q. No, please finish if you had something else.

A. Yeah, so, I mean, it's not uncommon that as a physician, right, if I have a clinical question, that I would go to the literature and look things up and to really examine that.

I can tell you that, in my practice, the risk for a procedural abortion in the first trimester,

whether a patient has a singleton IUP or a twin gestation, those two people would have similar risks.

Q. And is that also true for second-trimester procedural abortions?

A. Second-trimester procedural abortions have similar risks to the first. However, when -- it really just kind of depends on what the gestation is. We would certainly, in the second trimester, you know, be prepared for all the risks associated with the procedure.

Q. Have you looked at any documents or guidelines from the Plaintiff, Planned Parenthood South Atlantic, in this case?

A. I have reviewed the declarations from Dr. Farris.

Q. Have you looked at any independent documents beyond what Dr. Farris said in her declarations from Planned Parenthood South Atlantic?

A. No.

Q. So you're not basing any of your opinions on the actual guidelines or protocols from Planned Parenthood South Atlantic, are you?

A. I'm not employed by Planned Parenthood South Atlantic, so I don't know their specific protocols. What I do know is that Planned Parenthood Federation

of America convenes expert medical -- medically trained people, advanced practice clinicians, physicians, certified nurse midwives to review evidence related to all aspects of care that we provide at all affiliates, and there are standards related to those.

Q. So this is information that is shared nationwide among Planned Parenthood subsidiaries. Is that what you're saying?

A. Yeah. There's what -- there's a national group of medical experts that convenes and reviews evidence and ensures that we have the most up-to-date, evidence-based protocols to use in our health centers.

Q. But none of your opinions in this case are based on Planned Parenthood South Atlantic's internal guides or protocols, because you haven't seen any of those, correct?

A. I have not seen them with my eyeballs, but I suspect they are very similar to the ones we use here at Planned Parenthood North Central States.

Q. Did you read the laws at issue in this case in the process of developing your opinions?

A. I review -- I've read portions of them.

Q. Which portions did you read?

A. I mean, I can't -- I don't recall the

specifics, but I read the -- I read details related to both the hospitalization requirement and the portion that requires existence of -- documentation of the existence of an intrauterine pregnancy.

Q. And how did you know to just read those two excerpts from the laws?

A. In conversations with counsel, we reviewed those two specific themes and the portions of the law that pertain to them.

Q. So as part of your conversations with the Plaintiff's lawyers, you were given just specific excerpts of the laws, not the whole law themselves?

MS. GRANDIN: Objection. Calls for privileged information. You can answer to the extent you don't disclose any privileged communications.

THE WITNESS: We -- I'm sorry, can you repeat the question?

Q. (Mr. Boyle) Yeah. So you were talking about your conversations with counsel. And I was just asking specifically the conversations you had with the Plaintiff's counsel involved just them feeding you the specific excerpts, not the whole law, so you haven't read the whole law to base your opinion. Is that correct?

MS. GRANDIN: Same objection.

THE WITNESS: I am perfectly capable of scrolling and reading a PDF myself. And I'm also a very busy practicing clinician, and so I focused on the portions of the law that I was planning to provide expert testimony for.

Q. (Mr. Boyle) When were you first contacted by Plaintiffs to be their expert witness in this case?

A. In late July.

Q. Did you have -- well, I guess you didn't have anything to do with the temporary restraining order portion of the case leading up to July 1st. Is that correct?

A. That is correct.

Q. Okay. Do you agree that patient safety is always the most important consideration when you're treating a patient?

MS. GRANDIN: Objection to form.

THE WITNESS: Patient safety is absolutely near the top, yes.

Q. (Mr. Boyle) Do you always choose to treat your patients in the safest way?

A. I aim to.

Q. So as I understand it, you work for another affiliate of the Planned Parenthood Federation of America. Is that correct?

A. Yeah. So I'm employed by the University of Minnesota Medical School. I'm an associate professor in obstetrics and gynecology there. I'm also a board -- board certified in obstetrics and gynecology.

I'm also sub -- board certified in the subspecialty of complex family planning and I provide care at Planned Parenthood North Central States, as you just described.

Q. And so Planned Parenthood North Central States is like a branch -- subsidiary branch of Planned Parenthood Federation of America just like Planned Parenthood South Atlantic is a branch here in North Carolina. Is that fair?

A. Planned Parenthood North Central States is an affiliate, yeah. We -- that's how they are described. Uh-huh (yes). So there's over -- you know, sort of guiding principles and, like I said, medical standards, but each affiliate is responsible for, you know, the conduct of their -- of the healthcare provided within their health centers.

Q. And Dr. Farris is the director who runs the South -- Planned Parenthood South Atlantic. And you're the director and you run the Planned Parenthood Central North States, right?

A. I'm the director of research at Planned

Parenthood North Central States and I also serve as one of the associate medical directors. I am not the chief medical officer of Planned Parenthood North Central States.

Q. Do you know Dr. Farris personally?

A. I don't.

Q. Never met her at any Planned Parenthood convention or seminar or anything like that?

A. I have never met her directly.

Q. Excluding the lawyers who represent the Plaintiffs in this case, have you spoken to anyone else, to include other doctors perhaps, about your opinions in this case?

A. No. I mean, my husband knows I'm here, but he -- he's not medical and he wouldn't know anything I was speaking about if I tried to tell him.

Q. So you said you looked at Senate Bill 20 in the process of developing your opinions. Did you see where it defines possible complications that can arise from an induced abortion at North Carolina General Statue Section 90-21.81(2)a?

A. I mean, I'd have to see the text again to say whether or not I reviewed that portion.

Q. Okay. What is a uterine perforation?

A. A uterine perforation is a known risk of

procedural abortion when an instrument goes into the wall or through the wall of the uterus during the procedure.

Q. When you say "instrument," what do you mean by instrument?

A. A surgical instrument, either a suction cannula or a forceps, typically.

Q. And how does that happen during a procedural -- I'm sorry, surgical abortion?

A. How that happens, you know, really just depends on the -- on the case. It is a very low risk. It's a very -- it's a -- it's a known complication and one that I counsel patients about, but it is not very common.

Q. Do you agree that this is a possible complication that can arise from an induced abortion, surgical abortion, that should be disclosed to a pregnant woman who is a patient considering that type of abortion so that the patient can make an informed decision with more complete knowledge of the risks of the procedure?

MS. GRANDIN: Objection to form.

THE WITNESS: I believe all people should -- that are pregnant and considering abortion should be counseled on the risks and benefits of the

desired mode of abortion that they are considering.

Q. (Mr. Boyle) And who should inform the patient of that potential risk?

A. I mean, our whole healthcare team takes onus of that. But ultimately, it's my responsibility as the treating physician to ensure that the patient has good informed consent about the procedure that they have selected.

Q. And how -- I'm sorry, when should that patient be informed of this particular risk?

A. Prior to their procedural abortion.

Q. Are you aware that in -- under the North Carolina law, there's a 72-hour informed consent period where, after the initial counseling, the patient has to wait 72 hours before the induced abortion can occur?

A. I was not -- I'm -- I was not aware of that mandatory counseling wait, but that is a common thing that -- law that some patient -- some states have enacted accepting and exceptionalizing the healthcare that we provide during abortion care.

Q. What is a cervical laceration?

A. A cervical laceration is a tear that -- in the cervix.

Q. And how -- well, do you agree that a

cervical laceration is a possible complication that can arise from an induced abortion?

A. Yes. Mostly for -- mostly, we consider that risk for procedural abortion, and mostly in the second trimester.

Q. And how can that happen during a surgical abortion?

A. Again, the specifics of how those occur are unique to each case. And the overall risk of cervical lacerations at the time of procedural abortion is also very low.

Q. Well, how is it even possible that a cervical laceration could occur during a surgical abortion?

A. How it might occur would be related to during the evacuation part of the procedure, as the -- there are -- as the -- as we're guiding the fetus out through the cervix.

Q. So explain to me what you mean by that. How do you guide the fetus out through the cervix?

A. With instruments.

Q. What type of instruments?

A. It's -- it varies for each case. Typically, a combination, again, of suction and forceps.

Q. So forceps are, not to be indelicate, but

sort of like tongs like you would see in a kitchen? Is that what forceps ---

A. They do not look like ---

Q. A medical version?

A. They don't look like grilling tongs, no.

Q. What do they look like then?

A. I don't know. It's hard to -- really to describe that in words for a person who's -- I would guess never has seen one. I'd certainly be able to find an image for you if that would be helpful.

Q. Are they sharp?

A. No.

Q. Are they -- do they have rounded edges?

A. They do.

Q. How does something that's not sharp cause a laceration?

A. Mostly, that occurs because the cervix probably suboptimally responded to the preparation of the cervix that's typically employed, especially in the second trimester.

Q. So when we're talking second trimester, what weeks are we actually talking about?

A. The medical community, medical consensus about when the second trimester starts is at 14 weeks and zero days and continues until 27 weeks and six

days.

Q. And am I correct in understanding that that 14 weeks actually includes an extra two weeks for implantation?

A. Again, the medical community uses and dates a pregnancy starting with the first day of the last menstrual period.

Q. Okay. And how big is the baby or the fetus at 14 weeks when the second trimester starts?

A. It varies depending on the patient.

Q. What's the typical size?

A. I don't -- I don't know that there is a typical size.

Q. What's the expected range that you as a practicing OB/GYN, who has done this for at least nine years, expect to see?

A. Yeah. There are certain -- you know, there are certain calibrated measurements that we use with ultrasound that can give an estimated size, but that's a conglomeration of different measurements that -- that gives an estimated gestational age if someone doesn't have one already.

Q. And would that be head-to-rump measurements? Is that what it's called?

A. Not typically at 14 weeks. Typically at 14

weeks, we would use the biparietal diameter.

Q. What's that?

A. That's a measurement that can be performed with ultrasound that measures the biparietal diameter, the distance.

Q. Okay. When you say that, "biparietal diameter," what ---

A. Yeah.

Q. --- exactly is that?

A. It's the distance between the parietal bones.

Q. Where is that?

A. In the cranium.

Q. So it's the skull?

A. Colloquially, yes, skull.

Q. Which bones in the cranium or the skull is it that you're measuring there?

A. I'm sorry, what?

Q. Which part of the cranium or the skull are you measuring with the biperimetal (sic) diameter?

A. It's biparietal diameter. And again, it's the distance between both parietal bones. Yeah.

Q. What are the parietal bones in the skull?

A. They're bones of the skull.

Q. Well, I got a head and I can point to it.

Can you -- can you point to your head where the parietal bones are in the skull?

A. Well, I -- you know, again, for the sake of the transcript, I don't think that would be reflected very well. But I think, you know, the parietal bones on the side of -- both sides of the skull.

Q. Okay. So sort of right above the ears on an adult would be where the parietal bones are. Is that correct?

A. I don't know that I've ever measured a biparietal diameter on an adult. But, yes, on the fetus, that's where we measure them.

Q. Okay. So not the top, not the bottom. On the sides. Not the face, not the back of the head. Sort of above where the ears will eventually be if they're not already there, that's what you're measuring. Is that correct?

A. We measure, again, the distance between both visualized parietal bones on ultrasound. Kind of at the level of the thalamus, if you want to be more specific, so that's typically well above of the ears.

Q. So explain to me again what that measurement tells you and why it's important to guide your decision-making as the doctor who is performing the D&E abortion.

MS. GRANDIN: Objection to form.

THE WITNESS: The biparietal diameter in the early -- you know, in the second trimester, if one were using one single measurement for dating a pregnancy, is the best one for dating, providing a gestational age for the pregnancy if, again, a person doesn't have -- has not had an ultrasound previously.

Q. (Mr. Boyle) And why is that measurement important to inform you as the doctor about what types of tools you -- as I understand, you said that's the driving factor for what type of tools you use.

MS. GRANDIN: Objection to form.

THE WITNESS: Gestational age is a consideration sort of preoperatively about what my initial plan would be for how to accomplish a procedural abortion safely.

Q. (Mr. Boyle) Why? What exactly does it tell you? How does it inform your decision-making?

A. Because it -- because the size of the fetus is related to how we're able to accomplish the procedure.

Q. In what way does the size of the fetus or the baby impact your decision-making on how you accomplish the procedure?

A. Yeah. It dictates a lot of what instruments

we use, what kind of preparation of the cervix might be the safest and recommended for increased safety to decrease the risks of both perforation and cervical laceration like we've already discussed.

Q. So again, I'm still having trouble understanding how the forceps, which are rounded and not sharp cause a laceration in the cervix. Can you explain that to me, please?

A. Again, it -- it really just depends on the case. As the fetus comes through the cervix, there can be mismatch in size. There can be, as you know -- ossification of certain parts of the fetus can cause tears in the cervix also.

Q. When you say "ossification of certain parts of the fetus," are you saying that the fetus, the baby has developed bones that are hard which could be sharp and cause a cut?

A. The fetus ---

MS. GRANDIN: Objection to form.

THE WITNESS: The fetus certainly develops bones as it grows, yes.

Q. (Mr. Boyle) At what stage does the baby, the fetus, start to develop ossification or bones that could be hard enough that they could cause a cervical laceration?

A. I mean, we're -- to be honest, the -- laceration is something we always worry about, much more so in the second trimester. And again, the overall risk of that complication is extremely low. When it occurs, you know, we identify and treat it.

And when -- there's not a specific point in pregnancy where -- that I can, you know, define a week for you where that risk becomes exceedingly more high. Because it just -- it's always very low.

Q. Well, at week ten, you're doing an aspiration abortion, not a D&E abortion, right?

A. So -- I'm sorry, can -- will you repeat the question? I don't think I got it, the whole thing.

Q. At week ten -- and when I say "week," are we talking about gestational age, or is that a different thing? Are you saying gestational age when you say week?

A. Yeah. So if I -- if I say a pregnancy is ten weeks, that's -- I consider that the gestational age.

Q. Okay. So at ---

A. Calculated from the last menstrual period. Sorry to speak over.

Q. It's fine. I understand. So at week ten, gestational age, typically the baby or the fetus has

not developed any bones in its growth process. Is that correct?

A. Not necessarily. Organogenesis is -- begins, you know, sometime between the eighth and 12th week of pregnancy.

Q. Okay. So at week eight, you would say there's not likely going to be any bones or ossification in that baby/fetus. Is that correct?

A. I mean, it kind of depends. Certainly -- you know, certainly, it -- I don't -- I don't consider bones, you know, in the -- when I'm counseling a person about procedural abortion or continuing a pregnancy, for that matter, at eight weeks.

Q. Because you don't think that the baby or the fetus has developed bones in eight weeks. Is that correct?

A. No. Not necessarily. It's just when we -- you know, we're good at magnifying things with ultrasound quite a bit. At the end of an eight-week procedural abortion, there certainly wouldn't be identifiable bones for me to see with my -- with my eyes.

Q. But that would be different at the end of a 14-week ---

A. Potentially, yes.

Q. --- procedural abortion? Okay.

A. Uh-huh (yes).

Q. So walk me through what happens when you do an aspiration abortion versus a D&E abortion. What's the difference between those two? And please explain the difference by explaining what each one of them is.

A. Sure. A procedural abortion that involves aspiration alone would include dilation of the cervix and then evacuation of the pregnancy typically with suction alone.

Q. So I'm looking for a little bit more in depth. What does that actually mean when you say "suction alone"? What device do you use? How is it placed? What is it doing when it's placed? What happens afterwards?

MS. GRANDIN: Objection to form.

THE WITNESS: Yeah, that's kind of a lot of questions in a row, so I'm going to try to get them all. If I don't, please let me know.

So after dilation of the cervix, we pass a cannula, typically plastic. I've only ever used plastic ones in my professional career. And then the plastic cannula's attached to either handheld, so manual vacuum aspiration, or electric vacuum aspiration, you know, generated with a motor.

Q. (Mr. Boyle) So the plastic aspiration tube, what does that look like?

A. It looks like a plastic tube. It's typically clear.

Q. How big is the diameter?

A. So we -- cannulas are sized in diameter and measured in millimeters.

Q. So what is the size and measurement?

A. There are many different sizes of cannulas.

Q. So you have an array of options to choose from when you decide to do an aspiration abortion. Is that correct?

A. That is correct.

Q. How do you determine what size to use in a particular patient?

A. Yes. Typically, we have a prior plan, so a plan at -- you know, just prior to the start of the procedure of what cannula we're going to use to accomplish the abortion safely.

Q. And what is it that drives your planning on that? How do you make that plan?

A. Typically, the gestational age of the pregnancy.

Q. What does that impact? How does that impact your decision-making on what size of the cannula?

A. Because, in my experience, when we use an eight-millimeter cannula, for example, an eight-week pregnancy will pass through the cannula successfully.

Q. Okay. So when you say eight millimeters, that's the top-to-bottom diameter of the inside of the tube. Is that correct?

A. It's the -- it's diameter of the -- of the suction cannula, yes.

Q. And is it just a tube with a flush end opening that is placed and does the suction?

A. Yeah, so the suction cannula is attached either to a manual vacuum aspirator, which I don't have here in my office but I certainly could get one to show you, or electric suction via tubing.

Q. Okay. And if it's the manual version of suction, who is it that's actually manipulating that machine to create the suction?

A. The operating -- the operating healthcare provider.

Q. So the doctor, or a technician?

A. In our setting, a doctor.

Q. Okay. So if you're doing a manual aspiration abortion, you're the one actually turning the crank to create the suction on it?

A. It's not a -- it's not a crank. It's --

looks similar to maybe a large syringe. So there's a plunger, right, that once you create the seal at the top of the device, you pull back the plunger to create, you know, vacuum in the -- in the -- in the canister, in the -- you know, again, if you're a -- you know, thinking of it as akin to a syringe, right, you would pull back and then -- it's similar to that.

Q. Okay. And then the fetus is pulled through the cannula tube into that reservoir there that you're pulling the plunger back from. Is that correct?

A. Yeah. The pregnancy -- we evacuate the pregnancy into the -- into the canister.

Q. And does that also include the placenta and the other parts of the embryonic sac, et cetera, that is removed with the syringe or the plunger?

A. Yeah. So what comes into the canister -- and this would be for an induced abortion or for a missed abortion or what people would talk about -- you know, what people would call a miscarriage. We -- we evacuate all the tissue that's inside the uterus.

Typically, in the eighth week of pregnancy, for example, we don't talk about the tissue being placenta. It's really the -- the gestational sac and the villi. And again, in early pregnancy, there's

usually not an identifiable fetus. So it really just depends.

Q. At what point do you ---

A. Oh, sorry, may ---

Q. Go ahead.

A. --- can I go back ---

Q. Yeah.

A. --- for just a second? We also evacuate the decidual tissue, which is tissue that forms in the uterus, supporting tissue around the pregnancy.

Q. And do you do all of that, if it's manual, with just one pull, one time pulling back the plunger from the syringe device?

A. Many times, yes. Again, it really -- it really just depends. Our goal with any aspiration procedure is to ensure the uterus is empty at the end.

Q. So what do you do with the contents of that plunger when you're doing the manual aspiration abortion after you're completed with the procedure?

A. We examine the tissue to ensure we have the amount of tissue that we're expecting based on the gestational age of the pregnancy. And then there are laws governing the handling of pregnancy tissue in all states including Minnesota.

Q. Is that tissue used for any scientific

research or anything like that?

MS. GRANDIN: Objection to form.

THE WITNESS: In our setting, whether I'm providing abortion care at the University of Minnesota or at Planned Parenthood North Central States, we currently don't have that option for patients at this time.

Q. (Mr. Boyle) How is the material then treated? What is done with it then?

A. Yeah, we follow the laws in Minnesota regarding the disposal of pregnancy tissue.

Q. And what ---

A. And all tissue actually, whether or not I take -- you know, do a biopsy of the vulva or, you know, culture, exudate from a wound or something like that.

Q. What exactly does the law in Minnesota require you to do with that?

MS. GRANDIN: Objection. Calls for a legal conclusion.

THE WITNESS: The laws in Minnesota require that in -- well, I have -- most detailed knowledge about what -- you know, to be honest, at the University of Minnesota, pathology is the department that handles that. But here at Planned Parenthood

North Central States, we contract with a mortuary provider.

And we also offer the patients the option to make their own arrangements for handling of the fetal tissue after the procedure if that's their desire.

MR. BOYLE: Okay. I've got us at 58 minutes and I'd just as soon take a break if that's all right with everyone else. Is everyone okay with that?

MS. GRANDIN: Uh-huh (yes). Does ten minutes sound good?

MR. BOYLE: Ten minutes is fine.

THE COURT REPORTER: Off the record at 11:09 a.m.

(Brief recess: 11:09 a.m. to 11:20 a.m.)

THE COURT REPORTER: Back on the record at 11:20 a.m.

Q. (Mr. Boyle) Okay. Doctor, we were talking about the differences between aspiration abortion and D&E abortion. At what point does the fetus or the baby get to the size where you need to switch from doing an aspiration abortion to a D&E abortion?

A. In my practice, typically, that's around the 17th week.

Q. Okay. And so you said you use an

eight-millimeter cannula to do the suction with an aspiration abortion at an eight-week gestational age. What size cannula are you using at week 16 before you decide to switch to a D&E in week 17?

A. Yeah, typically, at 16 weeks, I would -- again, it kind of depends on the patient-specific characteristics, but generally I would try to start with a 16-millimeter cannula.

Q. Is it just a roughly number of weeks to number of millimeters decision?

A. That's a -- yeah, that's a general guideline.

Q. And again, going back to doing an aspiration abortion for twins or -- or triplets, do you need to know whether there are twins or triplets before you start that procedure?

A. To increase safety, no.

Q. Do you need to know for any reason?

A. Well, I think it's important -- you know, it's our standard practice to ask people, if they're having an ultrasound and the person who is pregnant, if they want to know whether or not they have a multiple gestation or not.

Q. Okay.

A. It's -- I mean, it's their body, so I think

that's important, you know, for -- piece of information to know whether or not the person who's pregnant wants to know that information.

Q. Is it important to the doctor performing the induced abortion?

A. Again, to increase safety, not really. It's my standard practice to use ultrasound during the procedure in the -- in the case of a multiple gestation.

Q. So when you've performed aspiration abortions, and I think you said you've only done it with twins, on a patient who's pregnant with twins, you use ultrasound during that procedure. Is that correct?

A. That -- yeah. I mean, generally speaking, yes, that is my -- the general way I do those procedures.

Q. Why?

A. Well, one of the ways, right, we know that the procedure is complete is how the uterus feels at the end, right? It feels empty. The other way we know the procedure is complete is by examining the products of conception after the procedure.

So, for example, if the patient has a six-week twin-gestation pregnancy, identifying the

pregnancy tissue at the end of the procedure and knowing for sure that a -- that we have both gestational sac -- gestational sacs present is a little bit harder, technically, to do.

And so in order to both ensure -- to ensure the uterus is empty at the completion of the procedure, I use ultrasound guidance.

Q. And so for that pregnant woman who is pregnant with twins that you do an aspiration abortion for at six weeks, you use an ultrasound during the actual procedure, during the aspiration abortion. Is that correct?

A. Correct.

Q. And how is it that you've come to know that that particular patient was pregnant with twins before you started that procedure?

A. Prior to procedural abortion, it's our practice to -- to review ultrasound records that the patient brings with them, for example, or to provide an ultrasound in our -- in our health center prior to procedural abortion.

Q. So when you are performing -- and when you say that, at your center, are you talking about at the hospital, or are you talking about at the Planned Parenthood clinic where you work?

A. In both settings, that would be true.

Q. So at both the hospital and at the Planned Parenthood clinic, before you do a procedural abortion, an aspiration abortion or a D&E abortion, you perform an ultrasound on those patients a hundred percent of the time. Is that correct?

A. I mean, as a experienced healthcare provider, I try not to say ever a hundred percent, because that's just not always possible. But, yes, it is -- it is our general practice to review records of an ultrasound previously or to provide one on the day -- or to provide one for a patient prior to a procedural abortion.

Q. And in your memory, have you actually performed an aspiration abortion on a woman who was pregnant with twins at six weeks gestational age?

A. I mean, the specifics at six weeks, I couldn't say for sure at six versus seven. But I certainly have provided a procedural abortion for a patient who had a twin gestation in the first trimester. That statement would certainly be accurate.

Q. Okay. We've talked about aspiration abortion. And if you would now, please explain what the details are of the D&E abortion, please.

A. "The details" meaning what?

Q. How do you do it?

A. Yeah. How we do it, again, depending on where somebody is in their -- in their pregnancy, they -- we may recommend some type of preparation of the cervix.

We know from data and guidelines from the Society of Family Planning, for example, that cervical preparation helps reduce the risk of the -- of a D&E procedure, especially in the -- later in the second trimester when we're providing that care.

Q. Why does -- first of all, what does preparation of the cervix entail? What does that mean?

A. Yeah. It might entail different things for -- for each individual, but may include a combination of the medication misoprostol, which we've talked about previously, and potentially the use of the medication mifepristone as well in preparation of the cervix. And then also placement of osmotic dilators.

Q. What is it you're trying to achieve with this preparation? What exactly is the point of it?

A. Yeah, we -- preparation of the cervix, if we can help the cervix soften some and provide a little bit of a dilation before the dilation and evacuation

starts, the risks of, in particular, cervical laceration decrease.

Q. When you say "dilation," does that mean increase the diameter of it?

A. Yeah. In -- you know, in obstetrics, commonly refer to a cervix as -- as dilated in centimeters. So, you know -- if we -- if I do an exam of the cervix and the cervix is open one centimeter, then I say the cervix is dilated one, one centimeter. And that would be true for before a dilation and evacuation or, you know, if I'm examining a patient's cervix at the end of a pregnancy in preparation for birth.

Q. What is the typical intent or level of dilation that you're trying to achieve when you perform a D&E abortion?

A. There's no -- there's no standardized number that is required before a person, you know, could have the start of their D&E, necessarily.

Q. Why does the size or the diameter of the cervix dilation matter then if -- what are you trying to do by dilating it if the particular size doesn't matter?

A. The greater the -- I mean, the -- you know, as the pregnancy advances, the pregnancy gets larger.

And therefore, we have to have, you know, a larger space with which to be able to complete that evacuation safely.

Q. Meaning the fetus or the baby is getting bigger as the pregnancy progresses and it's just a tighter fit to pull the bigger baby out if the cervix isn't dilated. Is that what you mean?

MS. GRANDIN: Objection to form.

THE WITNESS: Generally, when -- as we're, you know, providing a D&E for a patient, we need, you know, dilation of -- to some extent at -- at any gestation we're providing a D&E in order to be able to guide the products of conception through the cervix safely.

Q. (Mr. Boyle) And when you say guide them through, this isn't simply sticking -- this isn't simply applying a cannula, the tube, into the uterus and sucking out the contents because there's ossification and bone present and those bones won't go through the tube. Is that correct?

A. Well, the largest cannula that I've ever encountered in my practice is a 16-millimeter cannula. So that's the largest one we have at our -- at our ready to be able to use.

Q. Okay. I don't -- I don't see -- I don't

think that answered my question though.

A. Okay.

Q. And I'm not trying to be rude. I ---

A. Oh, no.

Q. I was asking if the reason you can't use just a cannula and do the aspiration at a certain point is because the fetus, the baby has gotten so big and the bones are developed and rigid, more rigid such that they won't just go through the tube. Is that correct, that's why you convert it to a D&E?

A. Yeah.

MS. GRANDIN: Objection to form.

THE WITNESS: It's a -- it's a little bit difficult to answer specifically because, for example, if there were a 17-millimeter cannula and I was providing a D&E abortion for a patient at 17 weeks of pregnancy, it's conceivable that we would be able to provide an aspiration abortion at that time as well.

Q. (Mr. Boyle) Okay. But since you have a 16-millimeter cannula as the largest option available, at 17 weeks gestation age -- gestational age, it's your medical opinion that you would not be able to suck the contents out through the 16-millimeter cannula. Is that correct?

A. It -- again, it depends a little bit on the nuances of each patient, but generally I don't expect to be able to complete the D&E at 17 weeks with aspiration alone.

Q. With the D&E procedure, do you -- well, first of all, what are the options or the array of options that you have for surgical instruments related to the D&E procedure?

A. Oh. I mean, we have many different -- well, I mean, again, like I said previously, we -- even at the -- even for a D&E, we use a combination of instruments, typically forceps and aspiration.

Q. Okay. So forceps is one type of surgical tool that you use during D&E.

A. Yes.

Q. Are there any others that you've ever used?

A. Well, let me think about that for a second. I don't think so, no.

Q. Okay. So when you say ---

A. I can't -- I can't recall a time.

Q. So when you say "surgical instruments," you're really talking about forceps. Is that correct?

A. Yes.

Q. And how big -- I mean, the forceps sort of have an X axis like scissors, if you will, and a clamp

on one end and a handle on the other end that you hold the handle in your hand. Is that correct?

A. How -- there certainly is a handle and then there's a -- on the end of the -- on the other -- on the opposite end of the forceps, there are, you know, fenestrations at the end that, you know, oppose each other directly, not necessarily in a, you know, crossing fashion like in a -- with a scissor.

Q. Right. They -- when you say fenestrations, are they like clamps or grabbers, like my hands here (demonstrates)?

A. Yeah, I mean, we call ---

MS. GRANDIN: Objection to form.

THE WITNESS: We call them fenestrations.

Q. (Mr. Boyle) Okay. Is there sort of a layperson word for fenestrations that you could help us understand?

A. There -- all the forceps I have used are metal. On the end of -- on the non-handle end of the forceps, there's typically a rounded opening -- rounded opening on either side that then, you know, can come together and touch each other.

Q. Two loops that come together and ---

A. Loop. Yeah, loop is a -- probably a

good ---

Q. Okay.

A. --- description. Yeah.

Q. And they're metal on the fenestration or looped end? That's a metal instrument?

A. All the forceps that I've ever used are entirely metal.

Q. And how big are those loops? Are they, say, one inch in diameter? Are they ten millimeters in diameter? What's -- what would you say the size -- or are there different sizes?

A. It really depends on the forceps. Forceps aren't sized necessarily like a -- like a suction cannula would be. So really it just depends on the -- on the forceps.

Q. Do you have multiple different forceps options, or is it all the same set of forceps you use every single time?

A. I have the same, you know, array of forceps available to me regardless of when I do or where I do a D&E, so both here at Planned Parenthood as well as at the university. You know, which one is required just depends on the, you know, individual patient characteristics, really.

Q. And when you say "on the individual patient

characteristics," are some of the forceps sort of wider at the fenestration or the loop side, the business end, if you will, the grabbers?

A. Sorry?

Q. Are they wider and bigger such that if the cervix isn't dilated to a certain point you wouldn't want to use the bigger one, you might use a smaller one?

MS. GRANDIN: Objection to form.

THE WITNESS: The -- there are certainly different -- you know, the diameter of the fenestration of the -- or loop of the forceps can vary depending on the -- on the forceps, yes.

Q. (Mr. Boyle) And you make a medical judgment based on the field presented, the operative field, as to what size forceps you choose. Is that correct?

A. Yeah. Generally, that's correct. You know, like with any -- certainly for D&E, that's similar to -- I mean, I don't use forceps for a diagnostic laparoscopy, for example. But I certainly would, you know, call for the instruments that made the most sense at the time based on my experience and training.

Q. So when you're performing a D&E, do you insert more than one forcep at a time inside the uterus or is it just one forcep at a time?

A. I have never inserted more than one -- or placed more than one forceps at a time.

Q. Okay. When you're doing a D&E and you place one forceps in -- tool in through the cervix into the patient's uterus, do you also have the cannula positioned through the cervix in the uterus at the same time?

A. No. I cannot recall a time where that was true.

Q. So when you're doing a D&E abortion, you don't have both the cannula and the forceps passing through the cervix at the same time. You only have one at a time. Is that correct?

A. Yeah. Generally, I think that's, yeah, been my experience.

Q. What do you do with the forceps? What is the actual technique that you are using those for in the D&E procedure?

A. Yeah. So after the -- I pass the forceps through the cervix, I open them gently and guide the products of conception out through the cervix.

Q. So you open the forceps gently, meaning you get the loops or the fenestrations apart. And then what do you do with them after you open it to guide the fetus or the baby out of the uterus?

A. Yeah, so after the forceps are open, then I would close them, and whatever -- and then remove whatever tissue is between the fenestrations of the forceps. That could be, you know, any part of the pregnancy, including the placenta.

Q. Okay. So you essentially put the forceps in closed, open them. Do you manipulate it at all at that point, or do you just open them and then close it?

A. Typically, manipulation is -- like you're describing is not -- is not part of my practice.

Q. Okay. So you open the forceps loops, you close them back and you then pull back the forceps through the cervix. Is that correct?

A. As I -- as I try to instruct our trainees, our resident physicians, it's very much more a guiding of the tissue versus pulling. And that -- you know, the nuances of that are sometimes lost on them. But we discuss that at length because we want the -- I want, as the physician, as the surgeon, for that tissue to come through the cervix safely.

Q. So the difference between guiding and pulling is sort of gently retracting it so it's not causing a cervical laceration. Is that the intent?

A. Yeah. To prevent forcing the tissue to --

to go somewhere where it doesn't actually fit.

Q. And when you -- how many times does it typically take for you to position the forceps inside the uterus, open the loops, close them back, guide tissue out? How many times of that does it typically take for you to complete a D&E abortion?

A. Oh, that's -- that's a good question. Sometimes very few if a cervix is dilated, you know, quite -- you know, significantly. Sometimes, you know, depending on, again, patient characteristics and, you know, position of the products of conception, sometimes more. But I've never -- I don't think I've ever actually counted how many times.

Q. Have you ever had a situation where you opened the forceps in the uterus, closed them, guided the tissue out, and the whole fetus came out at one time?

A. No. No.

Q. Instead, do you typically close the -- put -- place the forceps in the uterus, open them, close them, guide the tissue out, and it's a portion of the fetus's body, so not the whole entire fetus intact, but a portion of it?

MS. GRANDIN: Objection to form.

THE WITNESS: Yeah. Generally, in the

-- in the way that we provide dilation and abortion -- dilation and evacuation abortion -- sorry, excuse my flub there.

Dilation and evacuation abortion, yes, the patient is counseled that it is unlikely that the products of conception would come out intact.

Q. (Mr. Boyle) Do you ever have a situation where you're performing a D&E abortion where the skull or the cranium is too big to fit through the cervix so you have to do something to reduce the size of the skull?

A. I'm sorry, can you rephrase your question again? I just want to make sure I'm understanding it correctly.

Q. So you've got the cervix opening, let's say it's three centimeters dilated. And you've got the, I'm going to say it wrong but, parietal bone measurements of the cranium.

A. Uh-huh (yes).

Q. That is, say, five centimeters. So just it won't fit. What do you do in that situation when the skull is bigger than whatever dilation level you have the cervix?

MS. GRANDIN: Objection to form.

THE WITNESS: In that instance where

any part of the, you know, fetus is too large to pass through the cervix safely, then compressing the tissue is what we do.

Q. (Mr. Boyle) When you say you compress the tissue, speaking specifically about the skull itself, what do you mean by that?

A. That means the forceps is around the -- you know, we don't know specifically. On ultrasound, it's -- you know, for all my -- all my D&E procedures, I use ultrasound guidance. It's not always possible to know precisely what portion of the cranium that your forceps are, you know, directly on, but I -- we compress the tissue so that it will fit.

Q. So you compress the skull to collapse it. And then once it's collapsed, you extract it, you guide it back through the cervix. Is that what I understand?

A. Yeah. We compress ---

MS. GRANDIN: Objection to form. You can answer.

THE WITNESS: Thank you. We compress all the tissue so that it fits safely through the cervix.

Q. (Mr. Boyle) And the skull is the most -- typically the biggest part that provides the most

difficulty in that D&E procedure. Is that correct?

A. Certainly -- you know, certainly, that's the -- again, if you were going to use ultrasound measurements, typically, that's the -- in all -- at all of the gestations where we provide induced abortion care, that's the -- typically the widest part of the fetus, yes.

Q. Do you ever take the cannula and insert it into the uterus, pass it through the cervix into the uterus and try to reduce the size of the skull with the cannula before you try and remove it with the forceps?

A. So not as part of my Planned Parenthood practice. There have -- at the university, I can think of less than a handful of a number of times where, because of the anomaly affecting the pregnancy, the cranium was significantly larger than normal.

And in order to -- and in one case, actually, you know, had become entrapped. The patient wanted an induction of labor at 22 weeks, but the cranium became trapped in the cervix. So to help her complete, you know, her desired induction, we -- I, you know, decompressed the cranium that way with using aspiration instead.

Q. With the guiding of the different parts of

the baby or the fetus out of the uterus through the cervix, once you get a portion out with the forceps, you guide it through the cervix, what do you do next with that portion that's being clasped by the forceps?

A. After it's passed through the cervix?

Q. Yes.

A. Typically, I have a tray. You know, typically I'm seated for dilation and evacuation procedures and I have a tray that's resting on my lap. And after the tissue is removed safely through the cervix, then I place the tissue on the tray.

Q. Okay. So you don't use suction from the cannula once it's past the cervix. You just use the forceps to remove it from the body -- from the patient's body and put it in a tray not using suction. Is that correct?

MS. GRANDIN: Objection to form.

THE WITNESS: Yeah, I guess I just -- if I'm -- I guess I just want to make sure I understand the question correctly. So I've used the forceps to remove a portion of the products of conception through the cervix, out past the introitus of the pregnant person and then I place it on the tray.

Q. (Mr. Boyle) Okay. Yeah, I just didn't know

if once it -- I was asking if once you guided it through the cervix then you used the cannula ---

A. Oh, no.

Q. --- on that remnant and -- but, no, you extract it all the way sort of manually with the forceps ---

A. Yeah. That's my typical practice, yes, for sure.

Q. Do you use curettage for any of these surgical abortion procedures that you do?

A. Are you -- well, I mean, to be honest, the procedure in the first trimester is called a dilation and curettage, right, or D&C. But mostly -- so I guess it just depends on what you mean by curettage.

Q. What do you consider to be curettage?

A. I consider curettage to be use of a -- an actual curette, which is metal and has -- I'm not going to say sharp edges, but firm, thin edges, to -- again, I don't prefer the word scrape ---

Q. Sort of like a -- sort of like a tongue scrapper but for a different part of your body?

MS. GRANDIN: Objection to form.

THE WITNESS: I'm not sure what a tongue scrapper is but -- but, yeah, I mean, people colloquially kind of refer to curettage as scraping.

I think that's an intense word for what we're doing.

But I -- to, you know, get back to your question, if that's what we're defining as curettage, then I -- the last time I needed to use that in the setting of a procedural abortion was -- I don't know. It happens extremely rarely.

Q. (Mr. Boyle) Okay. With the D&E abortion, after you have used the forceps to grasp and guide the bigger portions of the fetus or baby out of the uterus, what do you do after you -- you're done with the forceps portion of the procedure?

A. Yeah, so once I'm confident that we have, you know, nearly all the products of conception evacuated safely from the uterus, then I would advance a suction cannula to the fundus of the uterus, or the top, and aspirate any remaining decidual tissue, typically, that still remains within the uterus.

Q. When you say, "the fundus," or the top, that's the part farthest away from the cervix, so sort of up towards the rib cage and the lungs, that direction of the body?

A. Yeah. I guess. It's the portion of the uterus typically the furthest away both from me as the operator, as the surgeon and, as you described, from the cervix, yes.

Q. Is there anything else about the D&E abortion procedure that you do that we didn't cover or that we've missed?

MS. GRANDIN: Objection to form.

THE WITNESS: As far as the procedural steps?

Q. (Mr. Boyle) Yes. The start to finish, how it -- how it actually unfolds and your process.

A. Yeah, I mean, for every procedure, we would start with a surgical timeout and make sure that the healthcare team, you know, was all on the same page and prepped and ready for the procedure that we planned. We discuss, you know, the patient's wishes, any allergies, planned anesthesia, type of specimen we will have at the end. You know, we do many things.

But if you're talking about the procedure, you know, the actual operating steps for me as surgeon, then we've described those pretty much in detail. The main last one is, you know, assessment of hemostasis and ensuring that bleeding is appropriate.

Q. You mentioned anesthesia. What type of anesthesia options are available for your patients who you are performing a D&E abortion on?

MS. GRANDIN: Objection to form.

THE WITNESS: The patients that I see

have a -- a very wide range of anesthesia options.

Q. (Mr. Boyle) Such as?

A. Such as it is standard practice to ---

Q. Go ahead and drink water. I didn't mean to interrupt you. I'm sorry.

A. Oh, that's okay.

Q. Take your time.

A. I got this one.

Q. Okay.

A. The standard practice, to use local anesthesia by the cervix for all patients unless, for example, a patient has a severe allergy. From there, patients can opt for mild sedation with medicine or moderate sedation with medicine, deep sedation with medicine or a general anesthesia.

Q. So local anesthesia, what's the actual anesthesia used there? Is it lidocaine or something like that?

A. Yeah. Typically, in our current practice, we use lidocaine plus or minus epinephrine.

Q. And that's standard for both aspiration and D&E unless the patient has a known allergy. Is that what I heard you say?

A. Yeah, generally, I think that's correct.

Q. Let's move on to the -- well, start at the

end. General anesthesia, that involves intubating a patient and putting them completely unconscious. Is that correct?

A. General -- again, I'm not an anesthesiologist, so this is my understanding of that realm of care. But general anesthesia involves medications for relaxation and then sometimes muscle paralysis, and then intubation with a endotracheal tube that then's connected to an anesthesia machine that provides oxygenation for the patient during that general anesthesia.

Q. You're not an anesthesiologist and ---

A. No.

Q. --- and so I'm ---

A. Thankfully, no.

Q. I'm not asking you for in-depth ---

A. Yeah.

Q. --- general anesthesia opinions. But ---

A. Good.

Q. --- is it safe to say that if your patient is going through one of these two surgical procedures, and they ask for general anesthesia, you are not providing the general anesthesia? Is that correct?

A. No, I am not providing general anesthesia.

Q. Okay. So if the -- if your patient is

having general anesthesia, is it correct that there is an anesthesiologist also involved in that procedure?

A. Yes.

Q. Do you perform any procedures outside of a hospital -- let me just -- let me rephrase that.

Do you perform any D&E or aspiration abortion procedures outside of a hospital that use general anesthesia?

A. No.

Q. Okay. So when it comes to general anesthesia, you do all of those patients in the hospital setting for those procedures. Is that correct?

A. Currently, yes.

Q. Mild sedation, what's the process with that? Are you the doctor who is actually administering the mild sedation?

A. Yes. So I would prescribe an oral medication, typically a benzodiazepine, for the patient to take prior to their procedure.

Q. Okay. And do you have specialized training, or do you require specialized anesthesia training to provide mild sedation to a patient?

A. The medications used for mild sedation for a procedural abortion would be similar to those that are

-- and the very same that are sometimes used for other conditions in medicine, for example, extreme anxiety. So any physician can prescribe those medicines.

Q. Okay. So it's within your practice, then, to conduct mild sedation using benzodiazepine oral medication. Is that correct?

A. Absolutely.

Q. Okay. So you are the responsible doctor prescribing the mild sedation oral medication for your patients who opt for that type of sedation for the D&E and aspiration abortions. Is that correct?

A. Yes.

Q. Okay. Moderate sedation, what does that involve?

A. Moderate sedation, in our setting -- again, the official anesthesia definition is based on the kind of level of responsiveness of the patient. But in our -- both of our settings, typically moderate sedation includes the combination of two intravenous medications.

Q. Which two?

A. Typically, we use fentanyl and midazolam.

Q. Is midazolam a benzodiazepine?

A. Yes.

Q. Are there any other ways that you are aware

of to provide moderate sedation in your practice?

A. Those are the two medications that we -- that we use for moderate sedation.

Q. And those are IV administered to your patients?

A. Yes.

Q. Are you the responsible doctor who is providing moderate sedation with those -- prescribing those two IV medications?

A. Yes.

Q. Can you perform mild and moderate sedation at the outpatient clinic, at the Planned Parenthood clinic that you perform surgical abortions at?

A. At Planned Parenthood North Central States, we offer patients who are having a procedural abortion to a -- you know, again, we talk to them about local anesthesia is a recommendation for any -- for everyone, and then give them the option to consider mild or moderate sedation if that's their preference.

Q. Okay. So you are acting within the scope of your practice in prescribing and monitoring patients who you're performing a surgical procedure on at the outpatient clinic when they opt for mild or moderate sedation. Is that correct?

A. Yes.

Q. Do you have any type of heart rate or oxygenation or any other type of monitoring on the patients who are undergoing moderate sedation?

A. We have extensive safety protocols regarding sedation of any kind in our -- in our setting -- in both settings, yes.

Q. And I'm speaking specifically about in the setting of your outpatient clinic, the Planned Parenthood clinic that you both provide clinical care at and are in the management of that clinic.

A. Uh-huh (yes).

Q. Do you have heart rate monitoring or oxygenation monitoring or respiratory monitoring for your patients who are undergoing moderate sedation there?

A. Yes. We are continually assessing vital signs throughout the procedure and measure heart rate and oxygenation during the procedure.

Q. So you actually have devices attached to the patient that have a constant monitoring of their heart rate and oxygenation. Is that correct?

A. That is correct.

Q. Okay. Do you have any anesthesiologists or CRNAs on-site at the Planned Parenthood clinic?

A. No, we don't. Because we can administer

moderate sedation or mild sedation, for that matter, safely in our setting ---

Q. Okay. So ---

A. --- without that.

Q. Sorry. So it's not required under Minnesota licensure and practice to have an actual specialist in anesthesia, either an anesthesiologist or a CRNA, present for you to prescribe mild or moderate sedation to your patient. Is that correct?

A. That is correct.

Q. Okay. Talk to me about -- well, and just to jump back to general anesthesia.

A. Sure.

Q. It is a requirement that you have a specialist, either an anesthesiologist or a CRNA or some combination of the two, if you're going to under -- if your patient is going to undergo general anesthesia. Is that correct?

A. I'm not trained in general anesthesia. So if my patient is planning that type of anesthesia, then, yes, I would -- I would request an anesthesia colleague to be present for that.

Q. And that does not occur at the outpatient Planned Parenthood clinic, the general anesthesia component. Is that correct?

A. Not currently.
Q. Has it ever?
A. No.
Q. Let's talk about deep sedation. What does that involve?
A. Deep sedation typically involves an IV medication called propofol.
Q. Is that it?
A. Yeah. Yes.
Q. Okay. So you're -- you've got a patient who chooses deep sedation, you're going to put that patient on IV propofol. Is that correct?
A. I don't administer intravenous propofol.
Q. Okay. So when a patient of yours selects deep sedation for an induced abortion surgical procedure, either D&E or an aspiration, you can't do that at the Planned Parenthood clinic, you have to do that at the hospital. Is that correct?
A. Current -- yes, currently all patients that desire deep sedation would be -- I would take care of them in the hospital setting.
Q. This IV propofol, when it's administered, do you have to have an anesthesiologist or a CRNA present to monitor the patient once the propofol is administered throughout the procedure?

A. Well, again, in my setting, that's typically the case. I don't know the specific -- because it's not a medication I administer, I don't know the specific -- you know, both -- you know, if there's any law about that, because I don't -- I don't do that. I'm not -- I don't ---

Q. And that's fair. It's outside your specialty.

A. Yeah.

Q. In your observation, you typically see some specialist, anesthesiology specialist monitoring that patient, but you don't know if that's required or not. Is that a fair way to say that?

A. So every patient that I've taken care of that has had propofol administered, yes, there is someone trained with specific -- I'm sorry, you know, has either a CRNA, typically, or an anesthesia resident or an anesthesia attending physician.

Q. And you would not convert a patient of yours in the Planned Parenthood setting -- if you were doing a aspiration or a D&E abortion in the Planned Parenthood clinic on your patient using mild or moderate sedation, you would not convert that patient to deep sedation during the procedure, would you?

A. During the procedure, no, we don't have --

we don't have the medications on-site for conversion to deep sedation.

Q. Have you reviewed the sedation policy that Planned Parenthood South Atlantic produced in discovery in this case?

A. I have not.

Q. Would you agree that, in your practice, you would not give your patients at the Planned Parenthood clinic an option of deep sedation at your clinic setting to perform an aspiration or D&E abortion?

A. Currently, with the capacity that we have in our health centers that provide procedural abortion, we do not offer deep sedation.

Q. Because you don't have any specialist there who can actually monitor the patient under deep sedation and it's outside your scope of practice. Is that correct?

A. Yes. Because I don't -- I don't administer medications like propofol.

Q. And you are aware of what your Planned Parenthood informed consent and sedation and -- minimal or moderate, paperwork looks like when you give your patients counseling about what type of sedation or anesthesia they have available to them? You're aware of that paperwork, right?

A. Yes.

Q. And you would not expect in your paperwork for the Minnesota Planned Parenthood clinic, where you are, that a patient could receive deep sedation at that Planned Parenthood clinic under any circumstance, right?

A. Well, for example, there may be an instance where we're planning to start offering that service where we would update the consent to reflect the option for deep sedation, you know, just prior to being able to offer that service.

Q. Are you aware of any anesthesiologists or CRNAs practicing at Planned Parenthood South Atlantic facilities in North Carolina?

MS. GRANDIN: Objection to form.

THE WITNESS: I don't know -- other than Dr. Farris, I don't know any other physician that's employed by Planned Parenthood South Atlantic.

Q. (Mr. Boyle) So you don't know of any general -- I'm sorry, you don't know of any anesthesiologist or CRNA who practices at or with any of the Planned Parenthood South Atlantic facilities in North Carolina. Is that correct?

A. Again, the -- really, the only physician I know in North Carolina is Dr. Farris and my residency

colleague ---

Q. Well, I ---

A. --- who is an obstetric and gynecology physician.

Q. But you agree it wouldn't be safe in your practice in Minnesota to provide deep sedation at a Planned Parenthood clinic where you work there?

MS. GRANDIN: Objection to form.

THE WITNESS: We -- we currently can't offer deep sedation based on the capacity and personnel that we have on staff.

Q. (Mr. Boyle) And you're not aware of any reason or any practice with the Planned Parenthood South Atlantic in North Carolina facilities that they can provide deep sedation, are you?

A. I'm not aware whether they can or they cannot. I don't -- I'm not sure what, you know, personnel are on the -- on the payroll for that organization.

Q. If they do not have any anesthesiologists or CRNAs who are present and able to provide care to patients at the Planned Parenthood clinics in North Carolina, would you agree that it's not appropriate for them to offer deep sedation?

A. The facilities that I'm aware of, none of

which are in -- you know, I don't really know the details about any facilities in North Carolina, the specifics. The facilities that I am aware of that primarily offer abortion care that have the opportunity to provide deep sedation do have typically either a CRNA or an anesthesiologist overseeing that type of sedation.

Q. So you don't know anything about Planned Parenthood South Atlantic North Carolina facilities, operations or guidelines, or who they have present to assist with the performance of surgical abortions. Is that correct?

MS. GRANDIN: Objection to form.

THE WITNESS: I know that they are very diligent about following the law in North Carolina. And I know, because they are a Planned Parenthood affiliate, that they have very -- very rigorous medically-evident -- you know, evidence-based guidelines for providing all the care they provide, including abortion care and including any type of sedation.

Q. (Mr. Boyle) You said you know that they're diligent about following the law. How do you know that? What facts do you have that inform your opinion about that?

A. I've read Dr. Farris's declarations in this case. And as an employee of a Planned Parenthood affiliate, I know the rigorous attention to the medical evidence that all affiliates must be up to date on and providing for their patients.

Q. But you don't have any specific facts about the North Carolina facilities. Is that correct?

A. I don't practice in North Carolina, so no.

Q. Do you know how far away from the North Carolina Planned Parenthood facilities the hospitals are located?

A. I do not.

Q. So you don't have any idea about how long it would take to transfer a patient from a Planned Parenthood facility in North Carolina to any hospital in North Carolina, do you?

A. I do not.

Q. So you don't have any opinions about whether it would be easy or not for Planned Parenthood North Carolina to transfer patients to hospitals in North Carolina, do you?

A. I'm afraid that I'm not very up to date on my North Carolina geography, no.

Q. I would've been shocked if your answer was different, but I just want to clarify. You don't know

anything about that ---

A. I lived in North Carolina once upon a time, but I have not.

Q. And I understand and I'm not trying to ---

A. No, that's okay.

Q. --- overkill it, but just so I'm clear on your answer. You don't have any opinions about whether there is a great distance between any Planned Parenthood facility in North Carolina and any hospital in North Carolina. Is that correct?

MS. GRANDIN: Objection to form. Apologies.

THE WITNESS: I don't have any information in my brain at this time about the distance, whether short or long or middle or however you would define those terms, between a health center -- Planned Parenthood health center in North Carolina and any type of hospital.

Q. (Mr. Boyle) And you don't have any idea about what Planned Parenthood in -- facilities in North Carolina's procedures are to transfer patients to North Carolina hospitals because you haven't seen any of that information. Is that correct?

A. I have not seen them. However, again, because I'm an employee of a Planned Parenthood

affiliate and I know the rigorous protocols that we have for -- regarding any patient that needs transfer out of our facility, I am quite certain that Planned Parenthood South Atlantic has a similar rigorous protocol for any type of occurrence where a person might need to be transferred out of the health center.

Q. Well, I appreciate that you think that is probably the case, and you may even be right. But as we sit here today, you don't have any factual basis to make that other than your speculation of how your experience is with the Planned Parenthood parent organization. Is that correct?

A. All facilities as part of a Planned Parenthood affiliate go through what's called accreditation. And safety protocols, including for patients that need transfer outside of the health center, are required to continue to be a Planned Parenthood affiliate.

So at that level, I do know that there is a safety protocol that exists.

Q. Well, I appreciate ---

A. But I have -- but you're correct, I have not seen it with my eyeballs.

Q. Okay. And I appreciate that I think what you're saying is is they all should be. But you don't

know even if these North Carolina Planned Parenthood facilities are accredited, do you?

MS. GRANDIN: Objection to form.

THE WITNESS: In order for the doors to be open, they must be up to date on accreditation.

Q. (Mr. Boyle) And again, not to get too deep, but I think what you're saying is in order for the doors to be open, they should be, but you don't know specifically whether they are or not in North Carolina, do you?

MS. GRANDIN: Objection to form.

THE WITNESS: I mean, it's hard for me -- I mean, I don't -- I don't have really any detailed knowledge about the safety protocols other than the ones that I use, so...

Q. (Mr. Boyle) And just to close the loop on that. So you don't have detailed knowledge about what's going on in the North Carolina facilities. Is that correct?

MS. GRANDIN: Objection to form.

THE WITNESS: Again, I know that in order to continue to be an accredited affiliate within our -- within in the Planned Parenthood Federation, that leadership in health centers must demonstrate that they are up to date and practicing in accordance

with the standards and guidelines of the federation.

Q. (Mr. Boyle) And you don't know if the North Carolina facilities have done that, do you?

A. I mean, I don't know what -- on a intimate level what other -- what any other physician is doing in their -- in their practice.

Q. And I appreciate that. But that means you don't know what's going on at the North Carolina Planned Parenthood facilities in that regard. Is that correct?

A. I have ---

MS. GRANDIN: Objection to form.

THE WITNESS: I have never been there or visited.

Q. (Mr. Boyle) And you don't know what's going on with their accreditation or their safety policies, do you?

MS. GRANDIN: Objection.

THE WITNESS: I can't -- it's hard for me to comment on care that's being provided in a place where -- you know, the specific details of that care when I've never been there to observe that care. I can speak most authoritatively to my own practice.

Q. (Mr. Boyle) Is infection a possible complication that can arise from induced abortion?

A. Infection is a known risk associated with pregnancy and also induced abortion, yes.

Q. Is bleeding or vaginal bleeding that qualifies as a Grade 2 or higher an adverse event -- I'm sorry.

Is bleeding or vaginal bleeding that qualifies as a Grade 2 or higher adverse event, according to the common terminology criteria for adverse events, a risk of a surgical abortion?

MS. GRANDIN: Objection to form.

THE WITNESS: Are you reading from a document that I could see, or -- I'm not sure what you mean by Grade 2. That's not standard terminology in my practice.

Q. (Mr. Boyle) Okay. Is bleeding or vaginal bleeding, heavy vaginal bleeding a risk that can accompany an induced abortion?

A. Heavy vaginal bleeding, which typically, honestly, arises from the uterus -- so, you know, heavy bleeding in pregnancy can occur with spontaneous abortion. It can happen with induced abortion. It can also happen at the time of giving birth.

Q. Is heavy bleeding a risk of both an induced abortion and a risk of an ectopic pregnancy?

A. Bleeding can see -- be seen with both a

patient having an induced abortion and an ectopic pregnancy.

Q. Do you agree that pulmonary embolism is a possible complication that can arise from induced abortion?

A. Pulmonary embolism, again, is a extremely rare complication that can happen as a -- as a result of being pregnant. It is extremely rare after a person has an induced abortion. It is much more common and likely after giving birth.

Q. Is it a risk of an induced abortion that you describe to your patients when you are counseling them about their decision of whether to have an induced abortion?

A. We talk to patients having any sort of procedure in pregnancy, whether that's a procedural abortion or a cesarean section, about the risk of blood clot.

Q. And do you include deep vein thrombosis in that category of risks that you discuss with your patients in those circumstances?

A. Yes. I mean, we usually -- the language that we use with patients is typically blood clot, because that's a little bit more -- it's easier to wrap your head around. Most people don't know the

term deep vein thrombosis. Really, the -- you know, correct term is venous thromboembolism or VTE, which would encompass a deep vein thrombosis and a pulmonary embolism.

Q. Okay.

MR. BOYLE: Folks, we've been going for another hour. I'm at two hours. I suggest we take a break unless folks are wanting to keep pushing ahead. What do you all think?

MS. GRANDIN: Yeah, let's take a break.

MR. BOYLE: Okay.

MS. GRANDIN: Work for you, Dr. Boraas?

THE WITNESS: Yeah, that's fine.

MR. BOYLE: Very good.

THE COURT REPORTER: Off record at 12:26 p.m.

(Brief recess: 12:26 p.m. to 12:39 p.m.)

THE COURT REPORTER: Back on the record at 12:39 p.m.

Q. (Mr. Boyle) Very good. Doctor, have you ever had to transfer a patient of yours who you were treating for an induced abortion, either surgical or chemical, from your Planned Parenthood clinic to a hospital because of a complication?

A. I have never had to transfer a patient with

a medication abortion. I have had a -- a patient that I had to transfer after a procedural abortion.

Q. How many patients have you had to transfer after a surgical abortion?

A. I actually don't have an exact number, but I can recall -- I can recall, you know -- I'm -- I -- it's certainly not even one per year. Yeah.

Q. So somewhere around ten would be the number?

A. No. I mean, the ones that I can recall, I can only recall transferring two people.

Q. Would you agree that pelvic inflammatory disease is a possible complication from -- that can arise from an induced abortion?

A. As a trained gynecologist, a pelvic inflammatory disease is something that arises from upper genital tract disease typically associated with an infectious process.

Q. Right. And infection, I think we've already gone over, is a complication that can arise from an induced abortion. So sort of derivative from that, would you agree that pelvic inflammatory disease is also a complication that can arise from an induced abortion?

A. So infection after an induced abortion -- you know, infection is a risk associated with

pregnancy and certainly with induced abortion as well. It's typically -- it's typically referred to as endometritis after a procedural abortion when we're talking about a infection that's affecting the uterus.

Q. Okay. Would you agree that endometritis, an infection of the uterus, is a possible complication that can arise from an induced abortion?

A. Yes. A very rare one.

Q. Okay. Would you agree that a missed ectopic pregnancy is a complication that can arise when you're providing an induced abortion for a patient?

A. I mean, if -- ectopic pregnancy is a -- is a reality of pregnancy in general. It's not more likely to be associated with induced abortion versus a population of people who aren't seeking an induced abortion.

Q. Okay. The general consensus, I believe, is that 2 percent of pregnant -- positive pregnancies are ectopic pregnancies. Is that correct?

A. I think, depending on the population, the exact point estimate differs, but somewhere between a -- probably a half point -- a half a percent up to three, depending on the population.

Q. And would you agree that a missed ectopic pregnancy, without regard to what the general sort of

prevalence of it is in any given population, that a missed ectopic pregnancy is a potential complication that can arise with providing an induced abortion to a patient?

A. I guess I'm not sure "missed" is the appropriate terminology here. People who come for induced abortion care are assessed for their risk of ectopic pregnancy regardless of what setting I'm working in in order to, you know, try to ensure the person is safe.

Q. If you have a patient who receives -- who you provide a chemical abortion to, and it's actually -- the patient actually has an ectopic pregnancy, do those two drugs that you provide the patient for the chemical abortion have any effect on the ectopic pregnancy?

A. The medicines that we use for medication abortion do not -- are not treatment for an ectopic pregnancy.

Q. So if the patient has an ectopic pregnancy and you are unaware of that and you provide a chemical abortion, that chemical abortion, those drugs, those two drugs that you provide that patient will not stop or end the ectopic pregnancy, will they?

A. So for a person that comes and requests a

medication abortion, we do extensive counseling about the expectations around what they might experience if they take the medicines, but also assess their risk for ectopic pregnancy.

So we certainly wouldn't provide medications for abortion like mifepristone and misoprostol if we thought a person had an ectopic pregnancy.

Q. Right. But sometimes you miss an ectopic pregnancy even if you do screening, right?

A. Sometimes, we're not able to diagnose it because we can't see it.

Q. On an ultrasound, right?

A. If a person has an ultrasound.

Q. So sometimes a patient who comes to you and asks for -- tests positive for pregnancy and asks for a chemical abortion has an ectopic pregnancy that you don't diagnose, and you give that patient the chemical abortion drugs, right?

A. So if someone screens low risk or -- and doesn't have an ultrasound or if a person has an ultrasound and we don't see an ectopic pregnancy, then those people can safely access medication abortion with mifepristone and misoprostol with close follow-up to ensure that the abortion was successful.

Q. But sometimes those people actually have an

ectopic pregnancy even if you think they were low risk or you took an ultrasound and did not locate the pregnancy. Is that correct?

A. Again, for a low-risk population, it's certainly something we discuss with people. But again, because the risk of ectopic pregnancy is so low, it's irrational to not provide the care that the person needs based on that very, very low risk unless that's a risk that's not acceptable to the patient.

Q. And I understand the question you're answering, but it's not really the question I'm asking.

A. Okay. Let me try again.

Q. Yeah. The -- and I appreciate your answer. It's fine. The question I am asking is, sometimes when those patients come to you, even if they are low risk after you screen them and even if you take an ultrasound and you cannot locate the pregnancy anywhere on the ultrasound: intrauterine, adnexa, wherever, sometimes those patients will have an ectopic pregnancy. Sometimes, it's too early to be seen on ultrasound and you just might not see it yet, but sometimes they will have an ectopic pregnancy, right?

A. Some -- a very small percentage of those may

go on to eventually be diagnosed with an ectopic pregnancy, yes.

Q. Okay. And in that situation, if you had a patient who you felt it was safe to give the chemical abortion drugs to even though they slipped through the screening process somehow and actually have an ectopic pregnancy, that particular patient who has ectopic pregnancy and chemical abortion drugs, those chemical abortion drugs don't do anything to stop the ectopic pregnancy, do they?

A. Not that is generally known within the medical community.

Q. Okay. Beyond unstudied and unsubstantiated possibilities, you use methotrexate to actually medically treat an ectopic pregnancy. Is that correct?

A. If a patient comes to me and has a known ectopic pregnancy, then I would -- based on, you know, various patient-level characteristics, I would discuss with that person their options for treatment, which would include expectant management with very close follow-up.

That meaning, you know, watch -- what colloquially people call "watch and wait" with good symptom assessment and, you know, kind of close

follow-up, or medication management with methotrexate typically, or a surgical procedure to treat the ectopic pregnancy.

Q. But in any event, the two chemical abortion drugs don't stop an ectopic pregnancy if they're given to a patient who actually has an ectopic pregnancy. Is that correct?

A. Not that we know.

Q. Okay. You agree that misoprostol has an FDA approval through ten weeks or 70 days. Is that correct?

A. Excuse me, can ---

MS. GRANDIN: Objection to form.

THE WITNESS: Can you say that again?

Q. (Mr. Boyle) Do you agree that the FDA has approved misoprostol through ten weeks or 70 days?

MS. GRANDIN: Objection.

THE WITNESS: Are you saying misoprostol, like m-i-s-o-p-r-o ---

Q. (Mr. Boyle) Mispronouncing that ---

A. Okay.

Q. --- because I have a terrible pronunciation ---

A. Oh, that's okay. I just wanted to make sure that I know what you're saying.

Q. Yes. I apologize.

A. Nope. Yep, that's okay. And your -- so now that I know what medicine you're discussing, can you say the rest of it again? I'm sorry.

Q. Yes. You agree that misoprostol has an FDA approval through ten weeks or 70 days, don't you?

MS. GRANDIN: Objection.

THE WITNESS: My understanding of the FDA label is that medication abortion with a combination of mifepristone and misoprostol, the FDA label discusses using those medicines through 70 days of pregnancy.

Q. (Mr. Boyle) Let me ask a question about your CV. And I'm sure I'm just not quite following. It says that you got your fellowship in family planning from the Magee-Womens Hospital. But when I look that up, it looks like that's not a fellowship program. Is it just under the umbrella of the University of Pittsburgh?

A. Yeah. Let me clarify. So -- well, I guess I can't think of a good -- but, so, yes, the fellowship educational, you know, umbrella is the University of Pittsburgh and the specific site is Magee-Womens Hospital ---

Q. Okay.

A. --- and associated clinics.

Q. And you also got a degree in clinical research. Is that a Ph.D. or...

A. I have a master's degree in epidemiology. And then during my fellowship, I completed a certificate in clinical research because I already, you know, had a preceding master's degree.

Q. What is the Consortium of Abortion Providers that you list in your CV?

A. The Consortium of Abortion Providers is a group of healthcare professionals that provide abortion care committed to, you know, examining the evidence and producing evidence to help ensure we take the best care of people.

Q. And I apologize, I may have said it all wrong.

A. Oh, no.

Q. Is it Mifeprex that has the 70-day FDA approval? I might've gotten those two confused. One of them has a 70-day approval. Is that correct? Or...

A. The combination of mifepristone and misoprostol for induced abortion care to 70 days ---

Q. Okay.

A. --- is my understanding of the FDA label.

Mifeprex is actually a brand name, so we try to stick to saying the generic name mifepristone.

Q. Okay. It's easier for -- I can actually say Mifeprex so ---

A. Yeah. Yeah.

Q. You list in your CV that you received a fellowship in reproductive health advocacy from a group called Physicians for Reproductive Health in 2014. Is that correct?

A. I did.

Q. And that's not a fellowship based on medicine or clinical research or clinical practice of medicine. Instead, it's a group of abortion-performing doctors who train how to speak to government officials and lobby them, and to speak to media and advocate for abortion. Is that correct?

A. The Physicians for Reproductive Health Leadership Training Academy was an opportunity that I was able to take advantage of because I was a fellow, but other physicians are able to apply for and be accepted into that program as well.

The fellowship included, yeah, evidence-based ways to communicate patient stories to multiple people, to coworkers, to family, to elected officials, to anybody really.

Q. Have you ever lobbied on behalf of abortion advocacy to any government officials?

A. I -- I'd have to look up the years to be specific, but I certainly have participated in ACOG, the American College of Obstetrics and Gynecology's, annual event called the Congressional Leadership Conference, which typically takes place in the spring. Although -- like spring, usually March, early April, approximately.

Which, again, lobbies for -- where we have the opportunity to talk with, ideally, our elected officials as constituents, but may -- this last time I participated was only staffers, about bills that are important for reproductive health generally.

So both for obstetric care as well as induced abortion and other aspects of ensuring people get the best healthcare when they're a young person seeking reproductive health.

Q. Do you agree that abortion -- induced abortion should not be banned after a certain point in a pregnancy?

A. I think bans severely -- I think any abortion ban severely limits our collective responsibility to people to ensure that they're able to access the healthcare that they need.

Q. So do you think, then, that abortion should be allowed up to a normal full-term pregnancy or 40 weeks gestational age?

MS. GRANDIN: Objection to form.

THE WITNESS: I have never met a patient who had a term pregnancy that desired an induced abortion.

Q. (Mr. Boyle) But do you support that type of induced abortion all the way up to the full term of pregnancy before the mother gives birth?

A. I think ---

MS. GRANDIN: Objection.

THE WITNESS: I think defining a gestational age week is hard, because there are many, many patient factors that go into that decision-making. And again, as an obstetrician, people who get to term pregnancy don't -- they don't want an abortion. They want -- they want to continue their pregnancy and give birth.

Q. (Mr. Boyle) Have you ever performed an induced abortion on a patient who was beyond 30 weeks gestational age in pregnancy?

MS. GRANDIN: Objection to form.

THE WITNESS: No.

Q. (Mr. Boyle) Do you think that there's any

limit that should be put on induced abortions at gestational age for any reason?

MS. GRANDIN: Objection.

THE WITNESS: I think limits -- I think blanket limits are harmful to patient autonomy.

Q. (Mr. Boyle) How many induced abortions have you performed of any type for an unborn child or fetus with a gestational age of 24 weeks or more?

MS. GRANDIN: Objection to form.

THE WITNESS: Again, I don't have a specific number. But because of the unique settings where I work, we are -- all of those patients that I would've taken care of in that gestational age range would've been diagnosed with a pregnancy with a life-limiting or a fatal lethal anomaly.

Q. (Mr. Boyle) So does Minnesota have laws that provide a limit to performing an induced abortion for a gestational age of the child or the fetus?

A. Minnesota does not have laws defining a specific gestational age week.

Q. You would agree that an unborn child or fetus, absent some anomaly like you mentioned, is typically viable or can live outside the womb after 24 weeks gestational age, wouldn't you?

MS. GRANDIN: Objection to form.

THE WITNESS: The general medical consensus about the periviable period, yes, includes the -- you know, the general consensus in my community is the 24 weeks and zero days would be a gestational age that if the patient, you know, had a complication of pregnancy that, with much support for many days, sometimes even more than a year, that fetus could be supported and -- outside the uterus.

Q. (Mr. Boyle) Could live outside the uterus, is that what you mean?

A. Yeah. Again, with support, typically extensive support.

Q. In your opinion, does the former North Carolina law that allowed abortion pretty openly up through 20 weeks, was that too restrictive in your opinion?

MS. GRANDIN: Objection to form. Calls for a legal conclusion.

THE WITNESS: Again, I think it's hard to define -- after sitting with many patients in this decision-making space, I think it's hard to define a specific week that honors the lived experience of patients.

Q. (Mr. Boyle) So you think a 20-week -- ban after 20 weeks is too restrictive?

MS. GRANDIN: Objection to form.

THE WITNESS: To be honest, I'm not in favor of any ban. But I think there are plenty of circumstances -- albeit if you look up, you know, the overall percentage of how many abortions occur after 20 weeks, the percentage is very low.

But again, for those patients, a ban after 20 weeks doesn't honor their lived experience and the need for that healthcare.

Q. (Mr. Boyle) You understand that at least some people have the opinion that an abortion should be restricted after the unborn child or fetus has a heartbeat or to the first trimester, and some of those people believe that the unborn child or fetus is a separate human being who has their own life and, absent an induced abortion, would be able to progress and live their own life? Do you understand that ---

MS. GRANDIN: Object ---

Q. (Mr. Boyle) --- some people ---

MS. GRANDIN: Objection to form.

Q. (Mr. Boyle) Do you understand that ---

MS. GRANDIN: Apologies. Objection, form.

MR. BOYLE: Okay.

Q. (Mr. Boyle) Do you understand that some

people have that opinion? Right?

MS. GRANDIN: Objection.

THE WITNESS: Can you restate again in the -- what opinion people have so I can answer?

Q. (Mr. Boyle) Sure. And I understand we're going to get an objection. So I'll try and say it all and then objection, and then you answer if we can, okay?

MS. GRANDIN: Apologies.

MR. BOYLE: No. No problem.

THE WITNESS: Sorry.

MR. BOYLE: I kept rambling. It's not your fault. I'll try it better this time.

Q. (Mr. Boyle) Do you understand that at least some people have the opinion that abortion should be restricted because the unborn child has a heartbeat in the first trimester at some point and that the unborn child is its own separate person that can have a life if allowed to progress and be born?

MS. GRANDIN: Objection to form.

THE WITNESS: I certainly, as a person who's awake many of the days in our country, understand that there are many legislatures trying to ban induced abortion care once fetal cardiac activity is detected on ultrasonography.

Q. (Mr. Boyle) So you're aware that some folks have that opinion. And I'm not suggesting you agree with it, but some people do have that opinion, right?

MS. GRANDIN: Objection.

THE WITNESS: I mean, I can't -- I can't know other people's opinions unless they tell them to me.

Q. (Mr. Boyle) Would you think that someone who has that opinion is just always unreasonable or irrational?

MS. GRANDIN: Objection to form.

THE WITNESS: I think -- I think that people are entitled to have beliefs about a lot of topics. Whether or not that relates to rationality, I think just depends on the topic.

Q. (Mr. Boyle) Well, and I appreciate that. On that particular topic, do you think it's just impossible for someone to have a reasonable opinion that says that?

MS. GRANDIN: Objection to form.

THE WITNESS: Yeah, I'm not -- I'm not entirely sure. I think the -- well, of exactly what you're asking. You know, like, if people -- if a person I met had the opinion that elephants were endemic to the United States, I would say that's

irrational. That's not based in fact.

Q. (Mr. Boyle) Do you perform induction abortions?

A. I see patients that are in the second trimester that prefer induction, decide to proceed with induction abortion versus dilation and evacuation, yes.

Q. And you have performed those induction abortions, right?

A. I take care of patients who need an induction termination of pregnancy, yes.

Q. Can you tell me what does an induction abortion entail? What are the -- sort of like we went through aspiration and then D&E ---

MS. GRANDIN: Objection. Apologies.

THE WITNESS: Yeah, I will -- I will do my best. So typically, for the patients that I see needing an induction of -- induction for -- to end the pregnancy, typically are, you know, seen through our clinic. They are counseled about their options. They -- and the rest of induction versus dilation and evacuation versus continuing the pregnancy.

When they've made their own best healthcare decisions and decided to proceed with induction, then they would be -- receive, ideally, would -- because

it's the evidence-based protocol, a combination of medications very similar to those people ending their pregnancy in the first trimester, which would include mifepristone and misoprostol.

Q. (Mr. Boyle) Is there anything beyond giving those patients who choose to have an induction abortion those two drugs that you do to perform the induction abortion?

A. The most effective regimen to ensure the successful completion of their termination of pregnancy via induction would be to administer mifepristone and misoprostol.

Typically -- well, at times, people are also interested and we counsel patients about the options for pain control during that process because it's a much longer process than dilation and evacuation would be.

Q. So as I understand it, an induction abortion performed later in the second trimester is really just like a chemical abortion that you'd perform in the first trimester, it just takes longer?

A. The combination ---

MS. GRANDIN: Objection to form. Go ahead.

THE WITNESS: The combination of

medicines is the exact same. The dosing of misoprostol is typically different.

Q. (Mr. Boyle) Is there any surgical or procedural component of an induction abortion in addition to the chemical or medicine?

A. So induction of labor in the second trimester, you know, one of the risks that we discuss with people is the need for a, you know, procedure during the process. Typically, that would be for concern for a significant amount of bleeding.

So that's one of the things that we discuss with patients when they're -- when they're deciding between mode -- the mode of ending the pregnancy in the second trimester.

Q. And what type of procedure is it that you would possibly need to perform during that induction abortion?

A. It kind of depends on the patient-level characteristics again. You know, the most common reason that people need a procedure would be for a retained placenta.

Q. And what type of procedure would you perform on a patient that had a retained placenta under those circumstances?

A. Well, you know, to, like, be the most

succinct, we go in and get the placenta. So -- and that depends on the provider, honestly, whether or not they would feel comfortable using an instrument like a forceps for that. Certainly, I do with ultrasound guidance. Other people, depending on their training, may use aspiration or suction alone.

Q. So you said the most common is retrieval of retained placenta. What other circumstances have you confronted in addition to that most common one?

A. Well, for -- I've never -- I've never needed to provide a procedure for a patient who was having an induction abortion in the second trimester other than to help the placenta -- you know, to evacuate the placenta.

Q. So the chemical abortion drugs are given in different doses to essentially stop the growth and development of the baby or the fetus at that point. And then the second drug promotes the uterus to expel the fetus or the baby, and basically the mother delivers the -- the now terminated baby or fetus. Is that correct?

A. That was a lot of steps for that question, so I'll just kind of describe what happens. So mifepristone -- the science behind mifepristone in use for induction termination of pregnancy in the second

trimester is really to provide cervical softening and also to provide the decidual necrosis so the supporting tissue around the pregnancy starts to be less supportive.

And then when we add misoprostol, when we administer misoprostol, the action of misoprostol is to provide uterine contraction so that the pregnancy will pass. Typically, patients need more than one dose of misoprostol to accomplish that fully.

Q. And so that would be a more fully formed baby/fetus that looked like a baby because it's later in the second trimester. Is that correct?

MS. GRANDIN: Objection to form.

THE WITNESS: It really depends on what gestational age we're talking about when the patient starts the induction of labor to -- for abortion. In my experience, people who select induction of labor versus a dilation and -- a dilation and evacuation are hoping that they will be able to see -- are hoping that the pregnancy will pass intact.

Q. (Mr. Boyle) Do you use a differential diagnosis in your clinical practice?

A. I would, yeah, venture to guess pretty much every day.

Q. Do you agree that a differential diagnosis

should include all of the possible risks or dangerous situations for a patient that you are treating?

A. I mean, a differential diagnosis is simply a list of possible diagnoses for a certain constellation of signs or symptoms that a patient is reporting.

Q. And typically when you develop that list of possible risks or situations a patient might be facing, your job as a doctor is to treat the worst first, right? You have to focus on the things that could be life threatening, don't you?

MS. GRANDIN: Objection to form.

THE WITNESS: My job is to -- to know the list and communicate the list of possible diagnoses to the patient. Only the patient can decide what risks and -- to accept for a given diagnosis. It's not my job to say what risks a person should accept or shouldn't.

Q. (Mr. Boyle) You said you're a member of ACOG, right?

A. I am a member of ACOG, yes.

Q. Do you follow and agree with the practice bulletins that ACOG publishes?

A. I mean, generally, I think that's true. Some of -- you know, there are committees that review those regularly.

Q. Do you agree that ACOG practice bulletins provide clinical management guidelines for OB/GYNs?

A. Generally speaking, yes. I think the hard part about practice bulletins, again, is it's a collated document of evidence about a specific topic, and patients, individual patients, you know, in my experience, don't always fit guidelines or, you know -- you know, fit specific algorithms.

So that's when the clinical judgment based on experience and training of each individual treating physician comes into play.

Q. You said in your report, your declaration, that you were asked whether there is any medical justification for the two challenged provisions in relation to the Court deciding the Preliminary Injunction Motion. Who asked you to do that?

A. Who asked me to serve as an expert witness in this case?

Q. Who asked you whether there was any medical justification for the two challenged provisions?

A. I would have to understand which challenged positions you're referring to, I guess, first.

Q. Right. I -- I think we talked earlier about the IUP documentation is one and then the 12 -- after 12-week hospitalization for induced abortion was the

other, right?

A. So I reviewed with counsel the -- my opinions based on experience and training for both the requirement for induced abortion care for rape and incest and life-limiting fetal anomaly to be provided in a hospital after the 12th week.

And I also discussed the specific portion about requiring the -- or documenting the existence of an intrauterine pregnancy before a medication abortion.

Q. Do you know what the legal standard is for those issues before the Court at the preliminary injunction?

MS. GRANDIN: Objection to form. Calls for a legal conclusion.

THE WITNESS: Yeah, I'm not an attorney, so I'm not sure I understand what you mean by "legal standard." I'm not -- I can't remember what you said.

Q. (Mr. Boyle) When you have a woman you're treating as your patient who has a positive pregnancy test, what do you consider to be on her differential diagnosis as potential medical risks and issues for her?

A. If I have a pregnant person sitting in front

of me, there are an exhaustive number of risks that I would think about for -- that might occur in a pregnancy.

Q. Such as?

A. Such as nausea and vomiting of pregnancy, such as high blood pressure diseases of pregnancy like gestational hypertension or preeclampsia. Like the need for a cesarean section, like the risk of pre-term birth, like the risk of a premature rupture of membranes, like bleeding in early pregnancy, the -- like -- I mean, the -- the list goes on.

Q. Do you consider the possibility of an ectopic pregnancy to be one of those risks that's immediately on every differential diagnosis ---

A. Of ---

Q. --- for your patients who have tested positive for pregnancy?

A. Yeah. If somebody calls and reports a positive pregnancy test at home, again, we would do a thorough screen of the patient's history and try to determine their risk for an ectopic pregnancy.

Q. Do you agree that unless they are discovered and treated early almost 40 percent of ectopic pregnancies rupture suddenly causing pain and bleeding in the abdominal cavity?

MS. GRANDIN: Objection to form.

THE WITNESS: I'd have to see the specific text where that exact number is quoted. I can, you know, say as a practicing gynecologist, you know, when we identify an ectopic pregnancy, we usually talk about -- we counsel patients about the risks and benefits of expectant management versus medical management versus surgical management.

Q. (Mr. Boyle) Do you agree that ruptured ectopic pregnancies can be fatal?

A. Can be what?

Q. Fatal.

A. Fatal. Yes. Although, thankfully, in the U.S., you know, in 2023, I don't know of a time where that's happened in my hospital.

Q. Has it ever happened, that you're aware of, from one of the Planned Parenthood patients that you see in Minnesota?

A. Nope. Not that I'm aware of.

Q. And we mentioned this earlier, and I got this number from the ACOG bulletin 193, which is the clinical management guidelines for OB/GYNs for tubal ectopic pregnancy from March of 2018. Are you familiar with this document, this bulletin?

A. I have seen ---

MS. GRANDIN: Objection. Go ahead.

THE WITNESS: I have seen this practice bulletin, yes.

Q. (Mr. Boyle) Okay. And that's -- this practice bulletin says, "According to the CDC, ectopic pregnancy accounts for approximately 2 percent of all reported pregnancies." Does that sound accurate to you?

MS. GRANDIN: Objection.

THE WITNESS: I mean, again, it would be best to view the document and -- in order for me to authoritatively answer that question.

Q. (Mr. Boyle) Do you have a copy of it in front of you?

A. Not currently.

Q. We had discussed having available these documents. Do you have the ability to pull that up and look at it?

A. Yes. I should have that ability.

Q. Yeah, just take your time and let me know when you get it.

A. Okay.

MS. GRANDIN: Are you introducing this as an exhibit, Mr. Boyle?

MR. BOYLE: Maybe.

MS. GRANDIN: Okay.

MR. BOYLE: I don't know yet.

THE WITNESS: Okay.

Q. (Mr. Boyle) Let me know when you get it pulled up.

A. I will. My computer is exceedingly slow.

Q. Yeah, that's why I always print these things.

MR. BOYLE: I'll tell you what. We're at about two hours and 50 minutes, and I'm not going to be done in ten or 15 minutes.

THE WITNESS: Okay.

MR. BOYLE: Do you want to take a little bit of a longer break now and -- maybe take 30 minutes and come back and finish up? And hopefully, you can get that pulled up in the interim.

THE WITNESS: Sure. That sounds fine to me.

MR. BOYLE: Does that work for you, Ms. Grandin?

MS. GRANDIN: Yes. Can we go off the record to talk about timing?

THE COURT REPORTER: Off the record at 1:23 p.m.

(Luncheon recess: 1:23 p.m. to 1:52 p.m.)

THE COURT REPORTER: Back on the record at 1:52 p.m.

Q. (Mr. Boyle) Okay. So, Doctor, do you have that ACOG Practice Bulletin 193 from March 2018 available?

A. I do. I have it pulled up here in PDF on my computer.

Q. Okay. Do you agree with the -- that ACOG bulletin 193 that, quote, "Despite improvements in diagnosis and management, ruptured ectopic pregnancy continues to be a significant cause of pregnancy-related mortality and morbidity.

"In 2011 to 2013, ruptured ectopic pregnancy accounted for 2.7 percent of all pregnancy-related deaths and was the leading cause of hemorrhage-related mortality," end quote?

A. Gosh, that's a long sentence. If you could point me kind of specifically in the document where you're discussing, then I can ---

Q. Yeah. In the first page, "Background Epidemiology," about halfway through that paragraph.

A. Okay.

Q. "Despite improvements..." Do you agree that that's what the ACOG says on this topic?

A. Yep. That -- what you read there is written

here in that -- in this practice bulletin, yes.

Q. Is that -- and you agree with the ACOG bulletin, right?

MS. GRANDIN: Objection to form.

THE WITNESS: You know, I haven't seen any specific mortality data related to ectopic pregnancy in those specific years, but I know ACOG takes, you know, the production of their practice bulletins very seriously.

Q. (Mr. Boyle) And you rely on these practice bulletins in your practice to provide you with clinical management guidelines, right?

A. As a -- as a starting point, sure. Yeah. Yes.

Q. If you look under -- sorry. If you look under the "Risk Factors" section, do you agree with ACOG that, quote, "Half of all women who receive a diagnosis of ectopic pregnancy do not have any known risk factors," end quote?

A. Yes.

Q. And so a lot of women who actually end up having an ectopic pregnancy don't have flags for known risks for an ectopic pregnancy. Is that correct?

A. Based in their history, not necessarily what's happening in their body currently, yes.

Q. At what stage in pregnancy do you normally screen a woman for an ectopic pregnancy?

A. Well, certainly if I'm taking care of a patient doing their prenatal care visit at 30 weeks, I usually don't discuss ectopic pregnancy at that time. I don't know if you're asking for a specific gestational age week.

I try to assess -- you know, once a pregnant person has had a positive test, a positive pregnancy test, we -- one of the first things we do is talk about how they're feeling in their body and ask about last menstrual period to try to assess an estimated gestational age of the pregnancy.

Q. And so as I understand it, whenever you become aware that your patients has -- patient has tested positive for pregnancy, you consider an ectopic pregnancy as a risk on that patient's differential diagnosis, right?

A. Generally speaking, sure. Yes.

Q. And you screen that patient as soon as you become aware that they're pregnant for ectopic pregnancy immediately, right?

A. I mean, we have -- in all the locations where I work, we have -- we have, you know, kind of general protocols about how to assess somebody's risk

for an ectopic pregnancy. One of which is, you know, just talking about past history, as we've described. The other is to talk about any current signs or symptoms that might be concerning for an ectopic pregnancy.

Q. And the gold standard to test and look for an ectopic pregnancy is to conduct a transvaginal ultrasound and see if there is an embryo or fetus inside the uterus. Isn't that right?

MS. GRANDIN: Objection to form.

THE WITNESS: There are, you know, kind of five main categories of early pregnancy. Much of which can rely on ultrasonography.

Q. (Mr. Boyle) Yeah. My question was, the gold standard to test and look for an ectopic pregnancy is to conduct a transvaginal ultrasound and see if there is an embryo or fetus seen in the uterus. Isn't that right?

A. The only ---

MS. GRANDIN: Objection to form.

THE WITNESS: The only way to definitively diagnose an ectopic pregnancy is to see an embryo outside of the uterus with ultrasound. It doesn't necessarily have to be a transvaginal one.

Q. (Mr. Boyle) Okay. So you can do a

ultrasound outside the woman's body ---

A. Again, it really -- it really just depends on the patient characteristics. But yes, we, at times, certainly can use transabdominal ultrasonography also.

Q. You said the only time you can definitively diagnose it is when you do the ultrasound and see the ectopic pregnancy. Did I hear you correctly?

A. So what -- if we're using ultrasound in early pregnancy, there are kind of five main diagnoses we could come up with, right? The first is a definite intrauterine pregnancy. The second is a probable intrauterine pregnancy. The third is a pregnancy of unknown location. The fourth is a probable ectopic pregnancy. And the fourth is -- or the fifth, excuse me, the fifth is a definite ectopic pregnancy.

Q. But under those categories, number one, if you do the ultrasound and you see the pregnancy inside the uterus, you've ruled out ectopic pregnancy there, right?

A. In the -- in the vast majority of cases, yes.

Q. You agree that you should always perform an ultrasound on a patient you provide care to when they test positive for pregnancy so that you can confirm if

the pregnancy is intrauterine by seeing it on an ultrasound, don't you?

MS. GRANDIN: Objection to form.

THE WITNESS: Not all patients in early pregnancy need an ultrasound.

Q. (Mr. Boyle) Why not?

A. Lots -- various reasons.

Q. Is there any contraindication to giving a patient an ultrasound?

A. The first and foremost would be the patient doesn't want one.

Q. But you can't see inside the patient's abdomen to see if the pregnancy is intrauterine or ectopic unless you do an ultrasound, can you?

A. The way I could see inside the abdomen would be to provide a laparoscopy or to provide an exploratory laparotomy or any imaging modality that we have available, such as ultrasound, such as CT, such as MRI.

Q. Right. But you're not going to do a exploratory surgery or an MRI. You just do an ultrasound to see where the pregnancy is, right?

MS. GRANDIN: Objection to form.

THE WITNESS: I would recommend an ultrasound if it was indicated.

Q. (Mr. Boyle) And a pregnant patient who you don't know if it's ectopic or not, you have ectopic pregnancy on that pregnant patient's differential diagnosis until you can confirm that it's in the uterus or not, correct?

A. There are many ways to assess a person's risk for an ectopic pregnancy. One of which is using ultrasound. There are many others.

Q. Do you agree with ACOG bulletin 193 which says, "The minimum diagnostic evaluation of a suspected ectopic pregnancy is transvaginal ultrasound evaluation and confirmation of pregnancy"?

A. Can you point me to exactly where in the document you're referring to?

Q. Yeah. It's on the second page under "Clinical Considerations and Recommendations. How is an ectopic pregnancy diagnosed?" I believe it's the first sentence there.

A. So for a patient with a suspected ectopic pregnancy, ultrasound can be very valuable. Most oftentimes, we would use a transvaginal ultrasonography. However, like I said previously, in select patients, transabdominal ultrasound -- ultrasonography would also suffice.

Q. Okay. So you agree with ACOG on that

particular sentence?

MS. GRANDIN: Objection to form.

THE WITNESS: I agree with the statement that diagnostic evaluation of a suspected ectopic pregnancy would -- you know, that ultrasound would be valuable in that case.

Q. (Mr. Boyle) But ectopic pregnancy is on the differential diagnosis for every pregnant woman until you actually rule it in or rule it out, isn't it?

A. That -- it's on the differential, but I don't suspect it in every case, partly because ectopic pregnancy is very rare compared to intrauterine pregnancy. And I also take many more factors about each individual patient into consideration when I'm deciding whether or not I suspect an ectopic pregnancy or not.

Q. All you'd have to do is do an ultrasound and you'd be able to tell one way or the other if it's intrauterine pregnancy or ectopic pregnancy. It doesn't seem that difficult. Why can't you do that for all your patients? Are you -- I don't understand.

A. Because ultrasound ---

MS. GRANDIN: Objection to form. Go ahead.

THE WITNESS: Because ultrasound isn't

indicated for every pregnant person that I see. Many people have pregnancies that don't -- that don't ever have an ultrasound.

Q. (Mr. Boyle) Do you agree with ACOG bulletin 193 where it says that, quote, "Serum hCG values alone should not be used to diagnose an ectopic pregnancy and should be correlated with the patient's history, symptoms and ultrasound findings," end quote?

A. Yeah, where in the document are -- is that section?

Q. If you look at the "Serum Human CHG -- hCG Measurement" section, second sentence.

A. Under the heading "Trends of Serial Serum Human Chorionic Gonadotropin," under that section?

Q. Yeah, under "Serum hCG Measurement."

A. Oh, okay, I see where you're saying now. And where?

Q. Second sentence.

A. Second sentence.

Q. Do you see that?

A. I see that the practice bulletin has that quote in it, yes.

Q. So you would agree that, at least according to the ACOG practice bulletin, it recommends that patients get ultrasound to determine the location of

the pregnancy?

A. In my practice, we use serum hCG levels in conjunction with patient history, symptoms and, at times, ultrasound.

Q. Right. And I understand that's what you say in your practice. But the ACOG here says that you use serum hCG with an ultrasound, right?

MS. GRANDIN: Objection to form.

THE WITNESS: It also states in the practice bulletin, the sentence immediately preceding that, that "Measurement of the serum hCG level aids in the diagnosis of women at risk of ectopic pregnancy."

Q. (Mr. Boyle) Right. It says it aids in it ---

A. It says ---

Q. --- however ---

A. The sentence to follow describes assessment of a patient at risk for ectopic pregnancy.

Q. And you just disagree that every patient is at risk for ectopic pregnancy because you think that the way you screen them means you don't have to consider certain patients at risk. Is that fair?

MS. GRANDIN: Objection to form.

THE WITNESS: Again, the only way to diagnose a definitive ectopic pregnancy is to see that

pregnancy outside the uterus. For patients that come in early pregnancy and request any care, including abortion care, we do a thorough history assessment and recommend the best care for that patient and consistent with medical evidence.

Q. (Mr. Boyle) And you've run studies on whether a patient who is pregnant needs an ultrasound to confirm an ectopic pregnancy early in their pregnancy or if you can just use screening to determine whether they are at risk for an ectopic pregnancy. Is that correct?

A. I have published articles assessing history-based screening in early pregnancy for abortion care, yes.

Q. And that is not the consensus position. It is what you are advocating for through your research should become the consensus position, but it is not established as the consensus position, is it?

A. By "consensus," are you referring to the practice bulletin?

Q. Yes.

A. The practice bulletin states, right, for people at risk of ectopic pregnancy, that serum hCG should correlate with patient history, symptoms and ultrasound findings. So we do our due diligence to

provide best healthcare to people to ensure that we are assessing people for either high risk for ectopic pregnancy or low risk for ectopic pregnancy.

You will also recall that this publication, the practice bulletin about tubal ectopic pregnancy, was published in March of 2018. So it is not uncommon when research is produced showing safety, for example, in this case, providing abortion for people with pregnancy of unknown location, that it takes a few years for those document -- consensus documents, as you referred to them, to be updated and published.

Q. (Mr. Boyle) And there isn't a consensus document from the ACOG that says your version of screening without ultrasound is accepted in the practice yet. Is that correct?

MS. GRANDIN: Objection to form.

THE WITNESS: The study that I published was just published in 2013, so I doubt -- I doubt they've had time to update the practice bulletin.

Q. (Mr. Boyle) And I think you just said it was published in 2013, but it was published in ---

A. I'm sorry, I meant 2023. I am so sorry.

Q. Yeah, yeah. That's okay. I was just ---

A. Thank you. Thank you ---

Q. No, I understood what you meant.

A. Yeah.

Q. Right. So -- and I appreciate that it's fairly new research. But even if it eventually gets adopted, the current standard of care for patients who appear with a pregnancy and you don't know if it's an ectopic pregnancy -- first of all, I think we've established -- let me clarify. You agree that every pregnant woman is at risk on some level for an ectopic pregnancy, right?

MS. GRANDIN: Objection to form.

THE WITNESS: No.

Q. (Mr. Boyle) You don't think that every woman who is pregnant, early in their pregnancy before you're able to establish through other means that it's intrauterine, you don't think you have to treat every single patient as potentially having an ectopic pregnancy when they test pregnant -- positive for pregnancy?

A. If someone hasn't -- doesn't have a intrauterine pregnancy or a probable intrauterine pregnancy, then, yes, we counsel those patients about the potential, albeit low, risk, right? We've discussed the risks of ectopic pregnancy generally in this deposition already. That low risk that a -- the

pregnancy may be growing outside the uterus.

Q. And it's fairly simple to conduct an ultrasound and find out if it's intrauterine, which would relieve that risk. Or if you see it ectopically, it would confirm the risk and you'd treat it that way. Or if you don't see it at all, then you still don't know, correct?

A. I would ---

MS. GRANDIN: Objection to form.

THE WITNESS: I would never perform an ultrasound for a patient that declined that care.

Q. (Mr. Boyle) So you agree, though, that the current status of the ACOG, based on bulletin 193, is that patients should be considered at risk for ectopic pregnancy and should be screened using ultrasound and possibly also serum hCG and history and other screenings, but at least ultrasound to determine whether they have an ectopic pregnancy?

MS. GRANDIN: Objection to form.

THE WITNESS: Again, according to ACOG in this bulletin that was published in 2018, I -- I'm not aware that the -- I don't know what the schedule of review of this practice bulletin is, but I agree that this practice bulletin from 2018 says that hCG values may be helpful when used in conjunction with

patient history, symptoms and potentially ultrasound findings for people at risk of ectopic pregnancy.

Q. (Mr. Boyle) Well, it doesn't say -- so you added, "and potentially." It doesn't say, "and potentially." It actually says, "and ultrasound findings," right?

A. It does.

Q. Okay. So it's including ultrasound in that process of screening a patient to determine whether you can rule in or rule out the ectopic pregnancy risk, correct?

A. As of 2018, that's what -- you know, the sentence says, "patient's history, symptoms, and ultrasound findings."

Q. And again, I'm not trying to exclude or diminish even your research. I've read it. I understand it exists. However, there is some scientific support for conducting an ultrasound with a patient based on this ACOG 193 bulletin. Wouldn't you agree?

A. There is for people at risk of ectopic pregnancy, again, in this -- this paragraph that we're discussing as part of -- as part of this practice bulletin, for people at risk of ectopic pregnancy, then hCG findings "should be correlated with patient's

history, symptoms, and ultrasound findings." That's what the practice bulletin says.

Q. Which you would agree provides some support for having an ultrasound to rule out or rule in that particular risk on every woman's differential diagnosis when she tests positive for pregnancy?

A. The practice ---

MS. GRANDIN: Objection to form.

THE WITNESS: The practice bulletin, again, is a starting point. And for the -- you know, when it's published, the best guidance that we have at that time for how to guide care for people within the obstetrics and gynecology practice.

Now, again, for each individual patient, I'm going to take that guidance and apply it to their specific characteristics and patient experience and then tailor that guidance based on the individual in front of me.

Q. (Mr. Boyle) I understand that and appreciate it and agree that's almost certainly appropriate ---

A. That, I would argue, is the standard of care that we've been -- been discussing.

Q. Okay. Very good.

I asked you earlier -- you've read the

Planned Parenthood South Atlantic documents that they provide to their patients related to informed consent for chemical abortion and for surgical abortion, haven't you?

A. I have not -- I have not read those documents, no.

Q. Okay. So if those documents inform a patient that is there to obtain a chemical abortion that they may have severe cramping and severe bleeding for several weeks, would you agree that those are similar symptoms that a patient who has a ruptured ectopic pregnancy might face?

A. If you're asking me to comment on specific documents, I'd have to review those.

Q. Well, I'm asking you a question. If a patient is told, "After you have the chemical abortion, the two-drug regime, you may experience heavy bleeding for even several weeks and blood clots the size of a lemon, and" -- you would agree that that patient could experience those symptoms but actually have a ruptured ectopic pregnancy and not be able to distinguish between having a ruptured ectopic pregnancy versus what the symptoms described as heavy bleeding were?

A. In my practice, we would counsel a person

about the main signs and symptoms of both ectopic pregnancy and induced abortion with medications so that they could really be in -- you know, the best in tune to their body and know when to access our 24-hour assistance line for assistance and help and -- and guidance if they were not sure if they needed it or if they thought they needed it.

Q. But you agree that the symptoms of a ruptured ectopic pregnancy can include things like bad pain in your abdomen, cramping and heavy bleeding, right?

A. The symptom -- what a person might experience with a ruptured ectopic pregnancy is typically different than the experience in the -- in the vast majority of cases for patients who access medication abortion.

Q. You say, "typically different," but they can be at least similar, right?

A. So the -- the symptoms that someone might have with an ectopic pregnancy are typically different.

Q. I -- I understand, typically they are different. But sometimes they're similar and could very well overlap. Is that correct?

A. The -- the symptoms a person might

experience with a ruptured ectopic pregnancy is going to be severe pain, typically unilaterally. They may experience pain with deep inspiration. They may experience lightheaded and dizziness.

They -- you know, it's not a typical experience of a person with ectopic pregnancy to have significant heavy bleeding noticeable on a pad, for example.

Q. I missed that last part. Can you -- can you say that -- I got confused.

A. Yeah.

Q. I thought you were talking about the chemical abortion. Were you talking about the ectopic?

A. A person with ectopic pregnancy may have some bleeding, but it's typically not very heavy when -- you know, when they're assessing the amount of bleeding they're having, like if they had a pad in their underwear.

Q. And -- well, you haven't looked at the Planned Parenthood for South Atlantic's documents that they produced in this case related to their informed consent. Is that correct?

A. I have not reviewed any Planned Parenthood South Atlantic documents, no.

Q. Okay. You don't know what the Planned Parenthood South Atlantic's protocol is for screening patients for ectopic pregnancy before performing a chemical abortion on them, do you?

A. Again, because -- in order to be an affiliate of the federation, I know that extensive protocols must be in place to continue to be an affiliate. So I know they have one. I just don't know the specific details of that.

Q. And I accept that you believe they exist, and I -- I think they do too. I haven't seen them. But more to the point, you have not seen them, correct?

MS. GRANDIN: Objection to form.

THE WITNESS: I have not seen any documents that Planned Parenthood South Atlantic uses.

Q. (Mr. Boyle) So you are unable to form any opinions about what Planned Parenthood South Atlantic's protocols are based on your review of those because you haven't reviewed them. Is that fair?

A. I haven't reviewed the documents. But again, because I'm an employee of Planned Parenthood North Central States, I understand the requirements that are necessary to continue to participate in the federation and continue to be a Planned Parenthood

site. So I know they exist. I just haven't seen the details of the specific documents.

Q. When is the typical gestational age of a pregnancy that you find yourself providing care to patients in your role in Minnesota?

A. Can you -- can you repeat the question, please?

Q. So you see patients who are testing positive for pregnancy. What's the typical earliest time that you will see that patient? Is it two weeks gestational age? Is it eight weeks gestational age, somewhere in between?

A. When they first make an appointment with me?

Q. When you see them, yes.

A. Oh, it can vary very widely.

Q. Do you typically -- do you agree that typically a woman wouldn't know that she is pregnant until four or five weeks gestational age just based on last menstrual cycle, et cetera?

A. The reason that the medical community uses and dates a pregnancy from the last menstrual period dates back from when we didn't have sophisticated ultrasound -- ultrasonography capacity. And, therefore, a person's first missed period would be a first sign for a person that they may be pregnant.

Q. Okay. So when you typically see patients that are early on, do you ever see patients that have a gestational age pregnancy of two or three weeks, or is it typically after five weeks gestational age?

A. I think, you know, people who -- once they realize they're pregnant and know they need to proceed with abortion care, they often call as soon as they can.

Q. I appreciate that and I don't dispute it. But what's your practical experience as, like, what's the gestational age when that happens?

A. Again, it's varied. Anywhere from -- I mean, a -- a person can make an appointment related to a pregnancy at any -- at any gestation that -- that they would prefer.

Some people, once they have that positive test, know they need to become -- that they need abortion care. So I've seen people in the -- in the third week of pregnancy, for example.

Q. Okay. And that's what I was asking. And so would you say third week of pregnancy is the earliest you've ever encountered a patient under those circumstances?

A. Probably.

Q. And ---

A. I don't write those -- I don't write them down, so I don't -- I don't -- probably.

Q. Have you ever provided an induced abortion to a patient who had a gestational age of less than five or six weeks?

A. Yes.

Q. When do you expect to be able to see a fetus or an embryo of one of your pregnant patients on an ultrasound?

A. General consensus about that is we -- if a person accepts a transvaginal ultrasonography, then we would expect to see a gestational sac starting as early as five weeks.

Q. Would you agree that it would be safer to confirm the intrauterine location of a pregnancy than to not know if it's an ectopic pregnancy using ultrasound when you're treating your patient?

A. I'm not sure I missed -- I think I missed the last part of that. Can you ask that again?

Q. When you're treating a pregnant patient, wouldn't you agree that it's safer for that patient to use ultrasound to rule in or rule out ectopic pregnancy before you provide that patient with a chemical abortion?

A. For a patient who we have assessed as low

risk for an ectopic pregnancy, no.

Q. Have you ever had a patient that you assessed as low risk for an ectopic pregnancy, you performed an induced abortion on that patient, and then later that patient turned out to have an ectopic pregnancy?

A. Okay. Say that one more time.

Q. Have you ever had a situation where you screened a patient, your screening process determined that the patient was low risk for ectopic pregnancy so you did not perform an ultrasound on that patient, you gave that patient a chemical abortion, and then later you found out that that patient had an ectopic pregnancy?

A. I'd have to -- I'd have to go back and look specifically at the -- the only time where that would have occurred -- I'm not sure. I'd have to go back and look.

Q. You can't say definitively that that's never happened?

A. Correct.

Q. And so you agree that there's a risk that, even if you determine a patient is low risk, they might have an ectopic pregnancy, right?

A. So I think, you know, the important thing

when we're counseling a person who's sitting in front of us requesting pregnancy care, including induced abortion care, is to review all of the risks, yeah.

So we go through those with the person, and then the patient accepts or does not accept those risks and decides for themselves how to proceed during that encounter.

Q. Would you be able to look back through your records and determine whether you had a patient that you screened, found that patient to be low risk for ectopic pregnancy, you did not provide them with a -- you did not take an ultrasound of that patient, you did provide them with a chemical abortion, and then afterwards they showed up as having an ectopic pregnancy?

MS. GRANDIN: Objection to form.

THE WITNESS: I could certainly look for that information. I think it ultimately is irrational to require that for every patient for these very, very rare instances even if that occurred in my practice.

Q. (Mr. Boyle) You used the word "irrational." Are you using that word because of the lawsuit? Is that why?

A. I'm using that word -- I don't know. It's

just the word I chose.

Q. Okay. You're not trying to couch it in terms of the law or the lawsuit when you say irrational?

A. I'm not an attorney, so I don't -- I don't know.

Q. Okay. Were you able to confirm that that patient who you saw at gestational age three weeks was pregnant?

A. (No audible answer)

Q. You mentioned earlier the earliest that you had treated a patient -- a pregnant patient was three weeks gestational age, right?

A. Yes.

Q. How were you able to confirm that patient was three weeks gestational age pregnancy?

A. The patient reported a sure last menstrual period, a history of regular, predictable menstrual cycles that lasted -- that were consistent with, you know, the -- her history of menstrual cycles, so we were able to date the pregnancy that way.

And this particular patient that I'm thinking about also had a urine pregnancy test in our health center.

Q. Did you perform an ultrasound on that

patient?

A. I mean, again, I -- it's my -- it's our standard practice to go through a protocol of history-based screening to determine whether or not we need to recommend an ultrasound for a person.

Q. You agree that induced abortion of any type is more complicated after the unborn child reaches the second trimester, don't you?

A. I'm -- I guess I'm not clear what you're asking.

Q. Complications for induced abortions increase, the risks increase the older the gestational age, so when you get to the second trimester it is more risky to perform an induced abortion in the second trimester than the first trimester. Is that correct?

A. Comparing a procedural abortion in the second trimester to a procedural abortion in the first trimester, yes, the risks are -- the risk, generally, for a procedural abortion increases as the gestation of the pregnancy increases. That would also be true for a person who decided to continue their pregnancy.

Q. Do you agree with the Academy of Medicine's article you cited from extensively when it says that, "The risk of serious complication increases with weeks

gestation. As the number of weeks increase, the invasiveness of the required procedures and the need for deeper levels of sedation also increase"?

A. Again, I'd have to review the specific portion of that document that you're, you know, alluding to to determine whether or not I agree with that. I think, generally speaking, you know, the academy didn't -- yeah, I'll just stop there.

Q. Do you agree with this statement: "The risk of serious complication increases with weeks gestation. As the number of weeks increase, the invasiveness of the required surgical procedure for an abortion and the need for deeper levels of sedation also increase"?

A. That was kind of a lot of things there. So generally, you know, as a person who doesn't -- you know, who recognizes the invasive nature of just having a pelvic exam, I don't -- I don't know exactly what the invasive portion means in that, that you're referring to. But generally, the -- again, for a procedural abortion, as the pregnancy advances, the risk -- the risk can increase.

Q. After 11 weeks gestational age, you don't perform a chemical abortion, right?

A. Not after 77 days.

Q. So every induced abortion ---

A. Or, I -- I'm sorry, let me -- can I ---

Q. Okay.

A. Sorry to interrupt.

Q. Sure.

A. Not -- in the first trimester, no, not after the -- after 77 days. If a person wanted induction termination abortion in my practice, then we would provide that.

Q. And the induction chemical abortion that you described earlier where you use more of the chemical drugs -- a higher dose, I should say, that's beyond the FDA-approved usage of those drugs also, isn't it?

A. When we're taking care of a patient for an induction termination in the second trimester, we use the medications off-label.

Q. And I think you said that you start using D&E abortion after 17 weeks. Is that correct?

A. Generally starting in the 17th week.

Q. Okay. So leading up to week 16, you would -- if you were doing a surgical abortion, it would be an aspiration abortion. Is that correct?

A. The vast majority of times, yes.

Q. And you would agree that the simple act of placing forceps and surgical tools repeatedly beyond

the cervix into the uterus increases the risk of both a cervical laceration and uterine perforation, wouldn't you?

MS. GRANDIN: Objection to form.

THE WITNESS: I don't -- I don't think I'm aware of any specific data showing a specific number of times that a person may need to pass a forceps to complete the dilation and evacuation as a known increased risk.

Q. (Mr. Boyle) So you don't think anybody's studied that?

A. I'm not aware of a study. That doesn't mean that it doesn't exist.

Q. You agree that sometimes patients who undergo surgical abortions need to have a blood transfusion as a complication of that procedure, don't you?

A. Yes. I'm aware that pregnant people need transfusions, including those, occasionally, that access induced abortion.

Q. Have you ever had one of your patients who you were performing a surgical abortion, either an aspiration or a D&E abortion, at the Planned Parenthood clinic that needed a blood transfusion during or soon after the procedure?

A. No.
Q. Okay.
A. Not to my knowledge.
Q. You agree that some, at least some, second-trimester induced abortions must occur in a hospital setting, don't you?
A. There are certain characteristics either associated with the pregnancy or associated with the patient that may make hospital-based care a recommendation.
Q. And about -- from my reading of your CV, about half of the second-trimester abortions that you perform, you perform in the hospital setting. Is that correct?
A. That information wouldn't be listed on my CV.
Q. Is it correct?
A. It's not correct.
Q. How many of the second-trimester abortions that you -- procedural, surgical abortions that you perform, what's the percentage breakdown of the ones that you do in the hospital setting versus in the Planned Parenthood clinic setting?
A. Again, speaking generally, I don't -- generally, sorry. I'm going to keep -- stop mumbling

for the transcript. Sorry.

So I provide dilation and evacuation abortion at both the hospital and Planned Parenthood North Central States. The exact numbers of -- numbers of patients I take care of at Planned Parenthood versus number of patients I take care of at the university, I don't have at the ready or in my brain.

The amount of time I spend, you know, providing procedural abortion at both of those locations, right, the university would be about a half day per week and Planned Parenthood would be about one full day per week.

Q. Okay. So would you say one-third of the -- well, let me ask before I go to that. When you say a half day at the hospital and a full day at the clinic, is that full day at the clinic focused solely on second-trimester surgical abortions?

A. No.

Q. What else do you do in that time when you're at the clinic?

A. When I'm providing care at the health center here in St. Paul, I -- we assess people for their need for whatever they make a -- an appointment for, honestly. So I provide medication abortion. I provide procedural abortion in the first and second

trimester. I assess people for management of miscarriage. I assess people for other pregnancy symptoms they may have in the first trimester.

Q. Okay. And as it relates to the hospital setting, that half day, is it not true that primarily what you're doing there are second-trimester surgical abortions?

A. I mean, the bulk of my procedural abortion care at the university is in the second trimester, yes.

Q. Okay. And ---

A. But it's not all -- it's not all that I do in the operating room.

Q. Okay. So taking just the second-trimester surgical abortions that you perform in the hospital and in the clinic, are they not roughly equal amounts at each place?

A. Again, I can only really tell you what the -- the amount of time that I spend at both of those places. I'd have to look at specific numbers to say anything about specific numbers.

Q. You're not able to just give a rough percentage based on you doing all of them yourself and knowing what that would be?

MS. GRANDIN: Objection to form.

THE WITNESS: I do many procedures, and there's no way I can keep them all in my head ---

MR. BOYLE: Okay.

THE WITNESS: --- regardless of whether it's for abortion or another obstetric and gynecologic problem.

Q. (Mr. Boyle) In any event, you do many second-trimester surgical abortions in a hospital setting every week. Is that fair?

A. It depends on what you define as many.

Q. More than five?

A. No.

Q. How many would you say you do on a weekly basis in the hospital setting?

A. Somewhere probably between one and four.

Q. Okay. Sorry, I'm closing out things, I've jumped around a little bit.

A. That's okay.

Q. Does the hospital where you work in Minnesota and you see patient -- pregnant patients to give them surgical abortions, does that hospital provide staff training for dealing with those types of patients and for patients who have survived sexual assaults?

MS. GRANDIN: Objection to form.

THE WITNESS: We -- I -- you know, I can't know what detailed training is required for all levels of staff that work in the hospital, so I'm not sure I can comment authoritatively on that question.

Q. (Mr. Boyle) Do you feel like the staff you work with at the hospital when you bring your patients to the hospital and perform abortions on them, do you feel like the hospital staff is adequately trained to react and deal with those patients?

A. I'm very privileged to work in a hospital that is very supportive of people's access of -- to comprehensive reproductive healthcare. My -- I have the feeling that many nurses, especially in the preoperative area, actually choose to work there and continue to work there because we're able to provide abortion care in the hospital.

Q. So you think that about your hospital in Minnesota, but you ---

A. I do.

Q. --- made or you gave opinions about the hospital staff in North Carolina. Do you recall that?

A. I do not.

Q. You don't recall saying that you think that the hospital staff in North Carolina aren't trained to properly deal with patients who are having abortion --

surgical abortion procedures?

MS. GRANDIN: Objection to form.

THE WITNESS: If you're referring to statements I made in my declaration, I'm happy to review that document in that specific area that you're, you know, discussing.

Q. (Mr. Boyle) Well, you don't remember saying that in your declaration that you provided in this case?

A. What I know to be true is that staff at Planned Parenthood are required to do extensive training at least annually, in my Planned Parenthood, at least annually to review how -- you know, sensitive exams and how to be present with a person that has experienced sexual assault. What I don't know is whether or not that's required for all staff at the hospital.

Q. And you're talking about at your hospital in Minnesota, right?

A. I am. Uh-huh (yes).

Q. And you don't know ---

A. And I certainly -- if I don't work at a place, I certainly wouldn't know the exact specifics that are required for all staff at any hospital in North Carolina. I'm sure the -- that differs greatly.

Q. Well, you cut me off, because that's where I was going.

A. Sorry.

Q. It's okay. I'm kidding.

Yeah, I just -- I just wanted to point out that you don't even know what the training is at your Minnesota hospital, so you don't have any opinions about what the training is for staff at any North Carolina hospital. Is that fair to say?

A. Oh, no, I have -- well, again, I can tell you from my experience in sitting with patients that, generally, people are much more prepared to sit with a person who's experienced sexual assault in my setting at Planned Parenthood than they are in the hospital.

Now, I'm not saying that the nurses who staff preoperative area are going to try to be disrespectful to a person that experienced or discloses that they've been a survivor of sexual assault, because, generally, I think the people who work there are pretty good people. But I'm not aware of any specific training that's required for them to be able to continue their job.

Q. Okay.

A. That also doesn't mean -- well, yeah. Never mind.

MR. BOYLE: Give me just a moment here.

Q. (Mr. Boyle) Let me ask you about the Goldberg study. Do you remember citing that?

A. I do.

Q. That's from 2022. He did a -- they -- he's the lead author, but they did a retrospective cohort study of medical records from Massachusetts Planned Parenthood entities related to giving chemical abortion drugs to a patient with a pregnancy of unknown location. Is that right?

A. Yes. My recollection of the Goldberg study was that they looked backwards, so retrospectively, at care that had already happened that they had provided for patients who presented for induced abortion care, were diagnosed with a pregnancy of unknown location and then requested medication abortion.

Q. And do you recall that 26 of -- well, so there were -- some part of the population decided to delay care and another smaller portion decided to go ahead and take the chemical abortion before there was a specific location of the pregnancy using ultrasound. Is that your recollection?

A. My recollection of that study is that there were two groups of people that they, again, sorted retrospectively that presented for care -- for

abortion care, were diagnosed with a pregnancy of unknown location, and then based on specific patient factors or counseling or the patient's own assessment of the best -- best way to proceed for them, either chose expectant management with close follow-up or proceeding on that day with induced abortion with medication and close follow-up.

Q. Okay. So do you recall that of the group that delayed care, that decided not to have a surgical or chemical abortion when they were initially told that they had a pregnancy of unknown location, do you recall that 26 percent of those patients who delayed care never needed to take the chemical abortion drugs at all because they either had an ectopic pregnancy or an early loss of pregnancy without any medication?

A. I'd have to ---

MS. GRANDIN: Objection to form.

THE WITNESS: Sorry, Kara.

I'd have to see the specific article to comment on specific percentages.

Q. (Mr. Boyle) Okay. If in fact that's what it said and it was 26 percent that did not need -- that delayed care, that did not need the chemical abortion drugs for those two reasons, because they either lost the pregnancy or they had an ectopic

pregnancy, if you extrapolate that to the patient population at large, that would mean that basically one out of four patients who have a pregnancy of unknown location would end up not needing to have the chemical abortion drugs. Do you agree with that?

A. I do not.

MS. GRANDIN: Objection to form.

Q. (Mr. Boyle) Why not?

A. I do not. Because that patient population, again, considering patient factors, patient history, patient's prior access, patient's own assessment of what is happening in their body, a good number of those people chose to remain in the delay-for-diagnosis group.

So again, blanket statements like that aren't honoring the fact that we do a very detailed assessment of patients' history and counsel them about their options. And in this study, you know, there were people who chose to -- you know, to proceed with expectant management.

Part of the reason that a patient might choose that management strategy is that they already think they're having a miscarriage. So I think that's probably more representative of -- of a portion of that group which they described "delay-for-diagnosis"

in their study.

Q. Did you include a delay-for-diagnosis cohort in your study from 2022?

A. Are you referring to my study from 2023?

Q. I'm sorry. Yeah, it was published in 2023, yes.

A. So our -- again, in our setting, our standard protocol for how to proceed when patients are diagnosed with a pregnancy of unknown location is to consider all the options for the patient. So that includes a detailed history, an assessment of a person's risk for ectopic pregnancy, and then also their own, you know, kind of collation of all that information about how they want to proceed.

So there are certainly patients in our setting and, you know -- I presume you've read or at least skimmed the article -- you know, we showed that that -- patients -- that our protocol for how we do that provides that care safely.

Q. Did you study a cohort that delayed after there was a pregnancy of unknown location -- or I'm sorry, after the -- well, yeah. After there was no ultrasound and you didn't know the location of the pregnancy, did you study a delayed cohort to see what happened to them?

A. In our 2023 study, all the patients had been diagnosed with a pregnancy of unknown location.

Q. Right. And ---

A. And some of those patients -- again, retrospectively, right? Some of those patients, you know, collating all the information that we go through with and the counseling we provide on the day of the encounter, chose to proceed with expectant management with close follow-up.

Q. Chose to have a chemical abortion, is that what you mean by that when ---

A. The other option ---

MS. GRANDIN: Objection to form. Go ahead.

THE WITNESS: The other option for a person diagnosed with a pregnancy of unknown location that's deemed low risk for ectopic pregnancy in our setting would include proceeding with medication abortion or a procedural abortion.

Q. (Mr. Boyle) And what was the first one you were describing? I missed that, I'm sorry.

A. Yeah. So if a patient comes into our health center requesting an abortion or made an abortion appointment and we diagnose a pregnancy of unknown location, then from there we do, you know, a detailed

assessment in correlation or in combination to assess a person's risk for ectopic pregnancy.

There are certain, you know, factors and patient-level characteristics that may make a person high risk for ectopic pregnancy. And then we have extensive protocols about how to ensure that patient gets referred out for sometimes, you know, same-day care or close follow-up with their -- with -- to, you know, kind of on -- continue to assess that risk.

Q. Okay. So did you study pregnancy of unknown location with three groups, one group that got chemical abortion, one group that got surgical abortion and then one group that delayed care and waited until they could confirm the location of the pregnancy?

A. Yes. Our study in 2023 included three groups. Patients chose -- after being diagnosed with pregnancy of unknown location and then assessed to be low risk for ectopic pregnancy, those patients chose either expectant management with close follow-up, medication abortion with close follow-up or procedural abortion for -- with close follow-up.

Q. And did some of those who chose expectant management with close follow-up turn out to have a loss of pregnancy or an ectopic pregnancy?

A. I'd have to look at the specific numbers in the article. But again, one of the reasons -- after counseling a person that's diagnosed with a pregnancy of unknown location, some of that is because the patient has had bleeding and suspects that they have had a miscarriage already. And we just can't know that with a single time point at a single encounter.

Q. So did some of those people who delayed their care end up having an ectopic pregnancy or having an early loss of pregnancy without any induced abortion?

A. I'd have to look at the specifics, but I think, again, because ectopic pregnancy, you know, is a part of early pregnancy, I -- I'm pretty sure there were ectopic pregnancies eventually diagnosed in all of the groups.

MS. GRANDIN: Pardon my interruption. I was just wondering if we could get a time check from you, Gretchen. Per my calculation, we're pretty close to four hours.

MR. BOYLE: I agree we are and I've got about two or three questions left. So if that's all right, I'll just proceed, but I'm not going much longer.

MS. GRANDIN: Okay. That sounds good.

MR. BOYLE: Okay.

MS. GRANDIN: Thank you.

MR. BOYLE: Thanks.

Q. (Mr. Boyle) Do you recall that the Goldberg study concluded that waiting to provide chemical abortion drugs until a patient has a confirmed intrauterine pregnancy is reasonably safe and effective?

A. That's not -- I mean, that's not the primary -- that's not my recollection of the primary conclusion that they drew from their study.

Q. Do you recall that it was at least a conclusion that he -- that they drew from their study?

A. I'd have to look specifically. You know, the conclusion that I recollected from that study was that providing abortion care for patients diagnosed with pregnancy of unknown location is safe and effective.

Q. Do you agree, though, that waiting to provide chemical abortion drugs until a patient has a confirmed intrauterine pregnancy is reasonably safe and effective?

A. I think, again, that doesn't honor patient experience very well. I think when we have a -- a perfectly safe and effective way to provide abortion

care in the setting of a pregnancy of unknown location, I think it's -- I think it's rather cruel to make a person wait.

MR. BOYLE: I don't think I have any further questions. Some of these other folks may have some. Doctor, I very much appreciate your time today. Thank you.

THE WITNESS: Indeed. I appreciate yours as well.

MS. GRANDIN: Do you mind if we take about ten minutes, and I might come up -- come back with a couple re-direct questions?

THE COURT REPORTER: Off the record at 2:58 p.m.

(Brief recess: 2:58 p.m. to 3:11 p.m.)

THE COURT REPORTER: Back on the record at 3:11 p.m.

EXAMINATION

BY MS. GRANDIN:

Q. Dr. Boraas, in your experience when a patient is seeking an abortion involving some level of sedation, who makes the decision about what level of sedation to give a patient?

A. You know, ultimately, it's the patient's decision.

Q. Does the anesthesiologist ever make that decision?

A. I would say the anesthesiologist strongly recommends a specific type of anesthesia, if there's an ---

Q. In your ---

A. --- if there's an anesthesiologist involved.

Q. In your experience, what factors often go into making the decision of what level of sedation a patient prefers?

A. Well, the first and foremost is what the patient desires. The second is, you know, occasionally we will see a patient that just requires a high -- a high level of sedation in order to complete the procedure safely.

Q. In your experience providing abortions, how often do patients choose deep sedation as their sedation option?

A. Well, again, the only place where people would have that -- would be able to access deep sedation would be in the hospital. And for various reasons, namely, the first and foremost being insurance coverage, that's a prohibitive option for many people in my setting.

Q. Do you have a general estimation, or is that

just -- is that not something you'd be able to provide an estimate of?

A. Deep sedation compared to general anesthesia?

Q. Deep sedation compared to other options I -- available.

A. Yeah, I think it really just depends on the patient. Many patients are nervous about any type of sedation and how it might affect their body.

Q. When a uterine perforation or a cervical laceration occurs during a procedural abortion, how do you generally treat that?

A. So treatment for both of those things is potentially different, so I'm going to talk about one at a time.

Q. Yes. Thank you.

A. No problem. If a perforation is suspected during a procedure, the next sort of -- not question, but the next thing that we assess is with what instrument because that -- that determines whether or not the patient -- whether or not we can ensure the integrity of the bowel.

If we can't ensure the integrity of the bowel, then the person has to have assessment of that surgically at the hospital.

If the perforation happens with a blunt instrument, especially in the first trimester, we're usually able to watch those patients closely in our outpatient health center, like at Planned Parenthood North Central States, and closely monitor vitals and pain level and just sort of overall patient assessment.

Sometimes potentially using ultrasound to -- and sometimes we're also able to, you know, monitor the patient safety in our health center.

Q. And I -- I think you answered this question in your general answer, but just to clarify. Does -- in general, when a uterine perforation occurs, does it always require treatment in a hospital?

A. No.

Q. And when a cervical laceration -- sorry, go ahead.

A. Yeah, sorry. I just remembered that you asked about cervical laceration, too, and I haven't answered that. So ---

Q. That's okay. Let me -- let me ask the question again specifically to cervical laceration. So when a cervical laceration occurs during a procedural abortion, how do you treat that?

A. It depends whether or not the -- the

laceration is low or in the distal portion of the cervix or whether it's higher and not as easily visible.

So for a distal or cervical laceration that occurs at the end of the cervix, those, if they're very small, can just be observed and make sure that they're not bleeding heavily. And if they're not, those can -- then those heal on their own.

If it's more -- if it's a slightly larger laceration or the laceration is bleeding a fair amount, then oftentimes we will reapproximate that laceration with suture, bring it together with suture and ensure that there isn't any ongoing bleeding.

Q. And ---

A. If ---

Q. Sorry, go ahead.

A. If the -- if the laceration is potentially higher, that may be treated with tamponade, like with a intrauterine balloon. And a fair number of times, that is sufficient for treatment of that. Higher lacerations sometimes need other procedures depending on where the -- where it is.

Q. So can a cervical laceration be treated safely in the clinic, an outpatient clinic where an abortion is performed?

A. Certain types of them, yes, absolutely.

Q. Does it -- is it always a requirement for surgical lacerations that the patient be treated in a hospital setting?

A. It is not always a requirement that cervical lacerations are better addressed in a hospital setting, no.

Q. Are forceps used in miscarriage management in your experience?

A. If I'm providing a dilation and evacuation to help complete a miscarriage for a patient, yes. Again, typically starting around the 17th week of pregnancy, that would be the same for a person experiencing a miscarriage also.

Q. Are forceps used in labor and delivery in your experience?

A. Yes.

Q. Is cervical ---

A. When a patient ---

Q. Sorry, go ahead.

A. Yeah. Yes, when a patient requires an operative vaginal delivery. Sometimes even at the time of C-section if the extraction is difficult.

Q. Is cervical laceration a possible complication of miscarriage management?

A. Yes.
Q. Is it a possible complication of labor and delivery?
A. Yes.
Q. Is uterine perforation a possible complication of miscarriage management?
A. Yes.
Q. Is it a possible complication of labor and delivery?
A. Yes.
Q. Is infection a possible complication of miscarriage management?
A. Yes.
Q. Is it a possible complication of labor and delivery?
A. Yes.
Q. Is hemorrhage a possible ---
(Off-record comments)
Q. (Ms. Grandin) Is hemorrhage a possible complication of miscarriage management?
A. Yes.
Q. Is it a possible complication of labor and delivery?
A. Yes.
Q. Does that include a hemorrhage requiring a

blood transfusion?

A. Hemorrhage requiring a blood transfusion is much more likely at the time of giving birth either vaginally or by a cesarean section than it would be for a person accessing induced abortion.

Q. In your opinion, do dilation and evacuation abortions need to be performed in a hospital in order to be performed safely?

A. No.

Q. So I think you testified earlier that you hadn't seen PPSAT's specific abortion protocols. However, you reviewed Dr. Farris's declaration submitted in support of the Amended Preliminary Injunction Motion in this case. Is that correct? Her two declarations?

A. I reviewed the declarations that Dr. Farris submitted, yes.

Q. What from Dr. Farris -- from your review of Dr. Farris's declaration, what is your understanding of PPSAT's protocol for a medication abortion in the circumstance where a patient has a pregnancy of unknown location?

A. From my review of Dr. Farris's declarations, the protocol at PPSAT would include assessment of patient's risk for ectopic pregnancy if they have been

diagnosed with a pregnancy of unknown location, and then a thorough review of the risks and benefits of expectant management in the setting of a PUL, pregnancy of unknown location, or proceeding with medication abortion or a procedural abortion.

And then my ---

Q. Do you -- sorry. Go ahead.

A. My -- again, from her declaration, my understanding of PPSAT's protocol regarding patients with a PUL also includes review of, you know, potential warning signs and symptoms associated with an ectopic pregnancy, as well as recommendation for very close follow-up.

Q. From your review of the -- Dr. Farris's declaration, do you understand that PPSAT in North Carolina uses hCG serial testing to evaluate patients who seek medication abortion but have a pregnancy of unknown location?

A. I do recall that from Dr. Farris's declaration.

Q. Do you recall whether PPSAT in North Carolina administers ultrasounds to patients who have a pregnancy of unknown location and seek medication abortion?

A. The only -- the only way to establish a

definitive diagnosis of pregnancy of unknown location is with ultrasonography. So, yes, if they're treating people with a pregnancy of unknown location, then they -- that person has had an ultrasound.

Q. Is it your understanding from Dr. Farris's declaration that PPSAT uses a similar protocol as the protocol whose safety and efficacy you discussed in your published research on the topic in your article from 2023 that we discussed previously in this deposition?

A. Our article does, in a box in the article, describe the protocol that we use here at Planned Parenthood North Central States. And it's -- from her declaration, the protocol that Dr. Farris described in the declarations seems very -- very similar.

MS. GRANDIN: Thank you, Dr. Boraas. I don't have any further questions.

MR. BOYLE: I have brief re-direct based on your questions if I might.

MS. GRANDIN: Okay.

THE WITNESS: Absolutely.

FURTHER EXAMINATION

BY MR. BOYLE:

Q. You were talking about bleeding from a cervical laceration. How do you see that? What

methodology do you use or mechanism do you use to visualize that? Do you just see it with your eyes, or are you using radiograph or some other testing?

A. Bleeding is visible with my eyes ---

Q. Okay. So you don't have like a fiber optic or something like that?

A. No. No fiber optics.

Q. Then how are you able to see it if it's -- not distal, but if it's the other one, farther away?

A. We would suspect a high cervical laceration if there was ongoing bleeding that wasn't coming from the top portion or fundus of the uterus.

Q. Well, you said some cervical lacerations should be treated in a hospital setting, right?

A. I didn't say that. I said many cervical lacerations can be safely treated in an outpatient setting.

Q. Which means the rest must be treated in a hospital setting, right?

A. There are certain -- you know, there are certain high cervical lacerations that don't respond enough to the measures that we use to treat them in the outpatient center. And then for those people, they may require transfer to a hospital.

Q. And you said that some uterine perforations

require hospital exploratory -- exploratory surgery of the abdomen in a hospital setting, right?

A. Some -- depending on what instrument and where the perforation in the uterus occurs and the potential risk for injury to the bowel in particular, some of those patients, yeah, need to be transferred for -- if the D&E happens in the outpatient setting, need to be transferred for that surgery in a hospital.

Q. You don't do any exploratory abdominal surgery to determine the scope of damage to different organs from a uterine perforation in your Planned Parenthood clinic in Minnesota, do you?

A. We don't provide any intraabdominal surgery at Planned Parenthood North Central States, no.

Q. And I know you haven't ---

A. However, if I'm taking care of that patient and that perforation occurs in the hospital, I would be present as the physician responsible and likely probably even start the case while we requested, you know, intraoperative consultation from the general surgeon.

Q. Right. But you wouldn't do that at the clinic. You would transfer that patient from the clinic to the hospital before you started that surgery, right?

A. That type of surgery requires general anesthesia, and we don't have that capacity at North -- Planned Parenthood North Central States.

Q. How do you get the serum hCG test from a patient? What do you do to collect that?

A. We draw their blood.

Q. How do you draw their blood?

A. With a needle.

Q. So do you take hCG testing of every patient before you give them a chemical abortion drug?

A. Not all patients accessing medication abortion need serum beta hCG testing.

Q. So is it your testimony that you have patients that you give chemical abortion drugs to that have neither had an ultrasound to confirm the location of the pregnancy nor had a serum hCG blood draw to test their pregnancy amounts, if you will?

MS. GRANDIN: Objection to form.

THE WITNESS: Testing serum hCG pregnancy amounts isn't really a thing in medical practice. The absolute value is rarely of helpful significance. It's really the trend over time that helps us take good, safe care of patients.

Now, there are certainly patients who screened, you know, after a thorough assessment to be

low risk for ectopic pregnancy and would need neither an ultrasound nor serum hCG testing.

Q. (Mr. Boyle) Okay. So in your practice in Minnesota at your Planned Parenthood clinic, you give patients -- on certain occasions, you give them chemical abortion drugs without performing an ultrasound on them or drawing blood to conduct the first in a series of serum hCG blood tests. Is that correct?

A. The provision of medication abortion without -- after a history-based screening without ultrasound or tests like serum hCG is well established in the medical literature to be safe and effective.

Q. And you do that at your clinic in the Planned Parenthood clinic in Minnesota. Is that correct?

A. For patients who screen out of the need for ultrasound, yes.

Q. And even if they don't have an ultrasound, you also sometimes don't have either an ultrasound or the blood draw, correct?

A. Those two things are not indicated for every medication abortion patient.

Q. Which is sort of the inverse of what I'm asking. So sometimes, you give those patients who

don't have an ultrasound and don't have the serum blood draw, you give them chemical abortion drugs. Is that correct?

A. If they are deemed to be a low-risk patient and have -- and that's what they choose as far as prevent -- proceeding with abortion care and are able to, you know, say that they'll, you know, complete the recommended follow-up.

Q. I feel like you left a yes off at the end there. Was there a yes that -- if all those things, then, yes, you do that?

A. If all those -- if all of those things are true about a individual in front of me, then yes.

Q. Okay. Lawyers are fun, aren't we?

A. You -- yeah, you all are fun.

Q. So -- and just so I understood your testimony before with Ms. Grandin, you said that it's your understanding that Planned Parenthood South Atlantic performs an ultrasound on every single pregnant patient before they provide that pregnant patient with a chemical abortion, just sometimes when they do the ultrasound it's indeterminate so you have a pregnancy of unknown location. Is that your understanding?

A. My understanding is that the law in North

Carolina -- again, not an expert on laws, specifically not in states where I don't practice. But my understanding of the law in North Carolina is that an ultrasound is required for each patient to access abortion care.

Now, certainly, as people are nervous about limits and bans on when they're able to access abortion care, there are certainly patients -- we've seen this for sure after the Dobbs decision, people making appointments earlier and earlier in pregnancy because they're worried they won't be able to access that care.

Q. Yeah. I'm trying ---

A. Then naturally, as far as, you know, how pregnancies progress, many of those people will be diagnosed with a pregnancy of unknown location because we don't reasonably expect to see an -- see a pregnancy on ultrasound, regardless of where it's growing.

Q. Fair enough. My question to you is, I thought I understood you to say that when you read Dr. Farris's declarations in this case that it's your understanding that she said every single patient who gets a chemical abortion in the Planned Parenthood South Atlantic clinic has an ultrasound taken of them

before they are given that medication. Is that correct?

A. My understanding of the protocol I'm specifically referring to in her declaration is about people who have been diagnosed with a pregnancy of unknown location.

That diagnosis can only happen -- a patient is -- has a pregnancy. We can diagnose a pregnancy with a urine pregnancy test, but we can't -- we can't diagnosis -- diagnose a pregnancy of unknown location unless we've -- unless we've -- unless the patient has had ultrasound.

Q. Or you can simply not take an ultrasound, and every patient without an ultrasound has a pregnancy of unknown location, right?

A. No.

Q. No?

A. No. A patient who hasn't had an ultrasound but has had confirmation of a pregnancy, for example, most commonly with a urine pregnancy test, that patient just has a pregnancy.

Q. I think you said this, and I promise this is my last one here. I just want to confirm.

A. Okay.

Q. Don't believe me because I'm a lawyer, but

I'm pretty sure this is my last question.

You're saying that every patient at Planned Parenthood South Atlantic who gets chemical abortion drugs has had an ultrasound. Is that your understanding?

A. My understanding is that the law requires ultrasound prior to abortion care in North Carolina.

Q. So that law, I believe, that you're talking about is currently enjoined, which, fancy legal word, means it's basically on the shelf until this hearing coming up at the end of September.

So are you saying that you think every single patient -- see, I told you I was going to ask another question -- every single patient at Planned Parenthood South Atlantic in North Carolina has an ultrasound because of that law or because of what you saw in Dr. Farris's declaration, which is it?

A. Dr. ---

MS. GRANDIN: Objection to form and calls for a legal conclusion.

THE WITNESS: Dr. Farris's declaration describes the protocol they use to help treat patients that are diagnosed with a -- a pregnancy of unknown location. And again, in order to diagnose a pregnancy of unknown location, a person would have to have an

ultrasound.

MR. BOYLE: Okay. I don't think I have any further questions.

THE COURT REPORTER: Anybody else?

All right. This concludes the deposition. The time is 3:34 p.m.

WHEREUPON, at 3:34 o'clock p.m., the deposition was adjourned.

CERTIFICATION

I, Gretchen Wells, Notary Public in and for the County of Iredell, State of North Carolina at Large, do hereby certify:

That said witness appeared before me, via video conference, at the time and place herein aforementioned and the foregoing consecutively numbered pages are a complete and accurate record of all the testimony given by said witness;

That the witness has executed a Declaration, which is attached as an exhibit hereto, and who made an attestation through this declaration that their testimony is truthful under the penalty of perjury;

That the undersigned is not of kin, nor in anywise associated with any of the parties to said cause of action, nor their counsel, and not interested in the event(s) thereof.

Reading and signing of the testimony was requested.

IN WITNESS WHEREOF, I have hereunto set my hand this 4th day of September, 2023.

Gretchen Wells

Notary No. 202110400230

WITNESS CERTIFICATION

I, CHRISTY MARIE BORAAS ALSLEBEN, MD, do hereby certify,

That I have read and examined the contents of the foregoing pages of record of testimony as given by me at the times and place herein aforementioned;

And that to the best of my knowledge and belief, the foregoing pages are a complete and accurate record of all the testimony given by me at said time, except as noted on the attached here (Addendum A).

I have ____ / have not ____ made changes/corrections to be attached.

_____
(WITNESS SIGNATURE)

I, _____, Notary Public for the County of _____, State of _____, do hereby certify:

That the herein-above named personally appeared before me this the _____ day of _____, 20____;

And that I personally witnessed the execution of this document for the intents and purposes herein above described.

_____
NOTARY PUBLIC

My Commission Expires: (SEAL)

ADDENDUM A

Upon the reading and examination of my testimony as herein transcribed, I note the following changes and/or corrections with accompanying reason(s) for said change/correction:

Page	Line	Is Amended to Read